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ATLANTIC CITY, JUNE 6, 7 AND 8, 1939

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Editorial and Executive Offices of the Society
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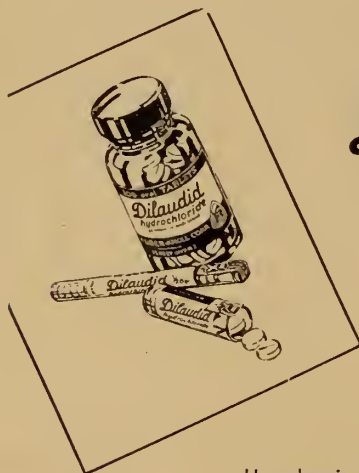
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Founded July 23, 1766

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TELEPHONE 9330

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Tel. Orange 5-1100

THE MEDICAL SOCIETY OF NEW JERSEY

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BEGINNING MAY 19, 1938

WILLIAM J. CARRINGTON, Atlantic City, President and Ex-Officio Member of Each

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HERSCHEL STRATTON MURPHY, *Chairman* Roselle
 WILLIAM HENRY VARNEY, *Vice-Chairman* Washington
 EDWIN GRAFING DEWIS Interlaken
 ROBERT MARTIN GRIER Pleasantville
 EDWARD CAFFRON KLEIN Newark
 AUGUSTUS S. KNIGHT Far Hills
 ADOLPH TOWBIN Lakewood
 WATSON BUDLONG MORRIS, *Consultant* Springfield

Meetings

Trenton.....June 5, 1938.....11 a. m.
 Trenton.....Oct. 2, 1938.....11 a. m.
 Trenton.....Dec. 4, 1938.....11 a. m.
 Trenton.....Feb. 19, 1939.....11 a. m.
 Trenton.....Apr. 16, 1939.....11 a. m.

Annual Meeting

CHARLES BUTCHER KAIGHN, *Chairman* Atlantic City
 CLARENCE LADELLE ANDREWS, *Chairman, Sub-Com. on Scientific Program* Atlantic City
 ASHER YAGUDA, *Chairman, Sub-Com. on Scientific Exhibits* Newark
 THOMAS McGRATH BRENNOCK Jersey City
 JOHN CLIFFORD CLARK Asbury Park
 WILLIAM JOHN CARRINGTON, *Consultant* Atlantic City

Meetings

Trenton.....Dec. 4, 1938.....11 a. m.
 Trenton.....Apr. 16, 1939.....11 a. m.

Auxiliary Medical Service

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 SAMUEL BARBASH, *Vice-Chairman* Atlantic City
 ARTURO RAYMOND CASILLI Elizabeth
 EUGENE GARFIELD HERBENER Lakewood
 SIGURD WALTER JOHNSON Passaic
 JEROME HOWARD SAMUEL Newark
 WALTER ALBERT TAYLOR Trenton
 ALFRED STAHL, *Consultant* Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
 Trenton.....Oct. 2, 1938.....11 a. m.
 Trenton.....Dec. 4, 1938.....11 a. m.
 Trenton.....Feb. 19, 1939.....11 a. m.
 Trenton.....Apr. 16, 1939.....11 a. m.

Cancer Control

WILLIAM GETTIER HERRMAN, *Chairman* Asbury Park
 HENRY BOYLAN ORTON, *Vice-Chairman* Newark
 HAROLD STERN DAVIDSON Atlantic City
 ELLWOOD EMERSON DOWNS Woodbury
 JOHN BUTLER FAISON Jersey City
 OTTO RUDOLPH HOLTERS Asbury Park
 JOSEPH HENRY KLER New Brunswick
 AUGUSTUS S. KNIGHT Far Hills
 CHARLES B. WOODMAN Morristown
 THOMAS BENJAMIN LEE, *Consultant* Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
 Trenton.....Oct. 2, 1938.....11 a. m.
 Trenton.....Dec. 4, 1938.....11 a. m.
 Trenton.....Feb. 19, 1939.....11 a. m.
 Trenton.....Apr. 16, 1939.....11 a. m.

Child Health

STANLEY NICHOLS, *Chairman* Long Branch
 WALTER BLAIR STEWART, *Vice-Chairman* Atlantic City
 ARTHUR FOWLER ACKERMAN Summit
 CHESTER BROWN Arlington
 ERNEST GARFIELD HUMMEL Camden
 IRVING OKIN Passaic
 LOUIS CHARLES ROSENBERG Newark
 ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Meetings

Trenton.....June 5, 1938.....11 a. m.
 Trenton.....Oct. 2, 1938.....11 a. m.
 Trenton.....Dec. 4, 1938.....11 a. m.
 Trenton.....Feb. 19, 1939.....11 a. m.
 Trenton.....Apr. 16, 1939.....11 a. m.

Constitution and By-Laws

JAMES FRANCIS NORTON, *Chairman* Jersey City
 DAVID KRAKER, *Vice-Chairman* Newark
 HERBERT WILLIAM NAFEY New Brunswick
 GEORGE N. J. SOMMER Trenton
 DAVID H. BARTINE ULMER Moorestown
 FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
 Trenton.....Feb. 19, 1939.....11 a. m.

Contract Practice

REUBEN LORE SHARP, *Chairman* Camden
 L. SAMUEL SICA, *Vice-Chairman* Trenton
 FRANK WILLIAM ASH Paterson
 JOHN GEORGE DECKER Hasbrouck Heights
 HENRY HAYWOOD New Brunswick
 HARVEY THEODORE HEROLD Newark
 EDWARD FREDERICK KLEIN Perth Amboy
 JENNINGS HOWARD HORNBERGER, *Consultant* Roeboling
 ANDREW C. RUOFF Union City

Meetings

Trenton.....June 5, 1938.....11 a. m.
 Trenton.....Oct. 2, 1938.....11 a. m.
 Trenton.....Dec. 4, 1938.....11 a. m.
 Trenton.....Feb. 19, 1939.....11 a. m.
 Trenton.....Apr. 16, 1939.....11 a. m.

Crippled Children

BABCLAY WELLINGTON MOVFAT, *Chairman* Red Bank
 ELMER PETER WEIGEL, *Vice-Chairman* Plainfield
 OSWALD RUDOLPH CARLANDER Camden
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 TOUFICK NICOLA Montclair
 HERBERT WILLIAM NAFEY, *Consultant* New Brunswick

Meetings

Trenton.....June 5, 1938.....11 a. m.
 Trenton.....Oct. 2, 1938.....11 a. m.
 Trenton.....Dec. 4, 1938.....11 a. m.
 Trenton.....Feb. 19, 1939.....11 a. m.
 Trenton.....Apr. 16, 1939.....11 a. m.

Finance and Budget

HARRY ROSS NORTH, <i>Chairman</i> (1939)	Trenton
HERSCHEL PETTIT (1942)	Ocean City
WELLS PHILLIPS EAGLETON (1943)	Newark
ANDREW FRANCIS MCBRIDE (1941)	Paterson
DAVID B. ALLMAN	Atlantic City
HENRY SPENCE	Jersey City
ELIAS JOSEPH MARSH, <i>Ex-Officio</i>	Paterson

Honorary Membership

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EPHRAIM ROLAND MULFORD	Burlington
FREDERIC JAMES QUIGLEY	Union City

No meetings, work carried on by correspondence.

Hospital Relationships

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WILLIAM H. A. WARNER, <i>Vice-Chairman</i>	East Orange
HENRY BRISTOL DECKER	Camden
FLORENTINE MILTON HOFFMAN	New Brunswick
CHARLES HYMAN	Atlantic City
ELTON WALLACE LANCE	Rahway
GEORGE O'HANLON	Jersey City
THOMAS KRAPPFEL LEWIS, <i>Consultant</i>	Camden

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Industrial Injuries and Occupational Diseases

J. IRVING FORT, <i>Chairman</i>	Newark
LESLIE EDWIN MYATT, <i>Vice-Chairman</i>	Bridgeton
CHARLES LITWIN	Teaneck
TRAUGOTT JOHN SCHUCK	Hoboken
JAMES HERBERT SPENCER, JR.	Franklin
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HENRY HOWARD KESSLER, <i>Technical Adviser</i> , representing Commissioner J. J. Toohy, N. J. Dept. of Labor	Newark
ROY GRIFFITH, <i>Technical Adviser</i> , representing the Manu- facturers' Association of New Jersey	Glen Ridge

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Legislation

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WENDALL JONES BURKETT	Pitman
HERBERT ROY VAN NESS	Newark
WILLIAM CRANE WILENTZ	Perth Amboy
SAMUEL ALEXANDER, <i>Consultant</i>	Park Ridge

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Others at call of Chairman

Maternal Welfare

ARTHUR WALTER BINGHAM, <i>Chairman</i>	East Orange
JOHN CARLISLE BROWN, <i>Vice-Chairman</i>	Atlantic City
SAMUEL ALLISON COSGROVE	Jersey City
GEORGE BURTON GERMAN	Camden
CARL HALLER ILL	Newark
JULIUS LEVY	Newark
ROBERT ABBE MACKENZIE	Asbury Park
WALTER BARCLAY MOUNT	Montclair
JAMES HARRIS UNDERWOOD	Woodbury
HARRISON BETTS WILSON	Hackensack
THOMAS BENJAMIN LEE, <i>Consultant</i>	Camden

Meetings

Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

January, 1939, Joint Meeting with County Maternal Committees and Field Physicians; date, hour, and place to be selected by Chairman, Dr. Bingham.

Medical Care of Indigent and Low-Wage Group

GEORGE WASHINGTON FITHIAN, <i>Chairman</i>	Perth Amboy
DAVID WRIGHT GREEN, <i>Vice-Chairman</i>	Salem
FRANK L. FIELD	Far Hills
DANIEL LEO HAGGERTY	Trenton
WARREN DAVID ROBBINS	Cape May
BYRON GRANT SHERMAN	Morristown
EDWARD MATHIAS ZEH HAWKES, <i>Consultant</i>	Newark

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Medical Defense and Insurance

CHRISTOPHER CHARLES BELING, <i>Chairman</i>	Newark
JOSEPH WALLACE HURFF, <i>Vice-Chairman</i>	Newark
JOHN CHARLES MCCOY	Paterson
GEORGE THOMAS TRACY	Beverly
WILLIAM CARTER WESCOTT	Atlantic City
WELLS PHILLIPS EAGLETON, <i>Consultant</i>	Newark

Meetings

Atlantic City....May 19, 1938.....	4 p. m.
Interim meetings at the call of Chairman	
Trenton.....Apr. 16, 1939.....	4 p. m.

Medical Practice

DAVID BACHARACH ALLMAN, <i>Chairman</i>	Atlantic City
SPENCER TREADWELL SNEDECOR, <i>Vice-Chairman</i>	Hackensack
HARRY NOAH COMANDO	Newark
GEORGE WASHINGTON FITHIAN	Perth Amboy
JACOB IRVING FORT	Newark
WILLIAM WALLACE MAVER	Jersey City
RBUBEN LORE SHARP	Camden
CHESTER ISAAC ULMER	Gibbstown
ANTHONY CHARLES ZEHNDER	Newark
THOMAS KRAPPFEL LEWIS, <i>Consultant</i>	Camden

Meetings

Atlantic City....May 19, 1938.....	4 p. m.
Trenton.....Apr. 16, 1939.....	4 p. m.

For meeting of Advisory Committees see their schedules

Mental Hygiene

JAMES STUART PLANT, <i>Chairman</i>	Newark
MARCUS ALBERT CURRY, <i>Vice-Chairman</i>	Greystone Park
WILLIAM COLE DAVIS	Atlantic City
BARCLAY STOKES FUHRMANN	Flemington
ALLEN GILBERT IRELAND	Trenton
EDWARD SHEAFE KRANS	Plainfield
CLARENCE MORTON TRIPPE	Asbury Park
HERBERT WILLIAM NAFEY, <i>Consultant</i>	New Brunswick
AMBROSE DOWD, <i>Technical Adviser</i> , representing Commis- sioner Ellis, N. J. Department of Institutions and Agencies	Newark

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

One or two other meetings at call of Chairman

Nursing and Nursing Education

ANTHONY CHARLES ZEHNDER, <i>Chairman</i>	Newark
GEORGE MILTON KNOWLES, <i>Vice-Chairman</i>	Hackensack
HORACE WESLEY JACK	Camden
VICTOR KNAPP	Asbury Park
FRANK LESLIE PERRY	Woodstown
HARRY SUBIN	Atlantic City
THOMAS J. FRANCIS WALSH	Elizabeth
WELLS PHILLIPS EAGLETON, <i>Consultant</i>	Newark

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Pharmaceutical Problems

CHESTER ISAAC ULMER, *Chairman*Gibbstown
REEVE LESLIE BALLINGER, *Vice-Chairman*Arlington
JACOB JOHN MANNPerth Amboy
MERWIN LESTER HUMMELMerchantville
CHARLES JOSEPH MURNPaterson
DANIEL WOOLSEY TELLER, JR.Morristown
RALPH KING HOLLINSHED, *Consultant*Westville

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Pneumonia Control

ROBERT ANTHONY KILDUFFE, *Chairman*Atlantic City
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HENRY PAUL DENGLERSpringfield
MARSHALL FLOWER LUMMISPitman
FREDERICK THOMAS VOSBURGHPassaic
RALPH KING HOLLINSHED, *Consultant*Westville
WILLIAM MACDONALD, *Technical Adviser*, representing
Dr. J. Lynn Mahaffey, Director N. J. Department of
HealthTrenton

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Post-Graduate Education

DAVID FULLER BENTLEY, *Chairman*Haddonfield
STUART ZEH HAWKES, *Vice-Chairman*Newark
ALBERT WILLIAM PIGOTTSkillman
ERNEST FRANCIS PURCELLTrenton
HAMMELL PIERCE SHIPPSDelanco
SLOAN GRIFFIN STEWARTAtlantic City
CLARENCE WILTON WAYSea Isle City
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.

Public Health

STANLEY NICHOLS, *Chairman*Long Branch
FREDERIC WILLIAM LATHROP, *Vice-Chairman*Plainfield
FRANK A. BIENIrvington
ARTHUR WALTER BINGHAMEast Orange
CHARLES BYRON BLAISDELLLong Branch
JACOB IRVING FORTNewark
ERNEST GARFIELD HUMMELCamden
ALLEN GILBERT IRELANDTrenton
ABRAHAM EZRA JAFFINJersey City
ROBERT ANTHONY KILDUFFEAtlantic City
ISAAC WARNER KNIGHTPitman
JULIUS LEVYNewark
BARCLAY WELLINGTON MOFFATAsbury Park
HERSCHEL STRATTON MURPHYRoselle
HENRY BOYLAN ORTONNewark
JAMES STUART PLANTNewark
ELBERT STETSON SHERMANNewark
*THEODOR TEIMERNewark
EDWARD MATHIAS ZEH HAWKES, *Consultant*Newark

Technical Advisers

ELLEN POTTER and EMIL FRANKEL, representing Wm. G. Ellis,
N. J. Dept. Institutions and Agencies.
HENRY HOWARD KESSLER, representing J. J. Toohey, N. J.
Dept. of Labor.
WILLIAM MACDONALD, representing Director Mahaffey, N. J.
Dept. of Health.
HOWARD DARE WHITE, representing Director Elliott, N. J.
Dept. of Public Instruction.

Meetings

Long Branch.....July 10, 1938.....3 p.m.
Newark.....Sept. 7, 1938.....3 p.m.
Newark.....Oct. 5, 1938.....3 p.m.
Newark.....Nov. 2, 1938.....3 p.m.
Newark.....Dec. 7, 1938.....3 p.m.
Newark.....Jan. 4, 1939.....3 p.m.
Newark.....Feb. 1, 1939.....3 p.m.
Newark.....Mar. 1, 1939.....3 p.m.
Newark.....Apr. 5, 1939.....3 p.m.
Newark.....May 3, 1939.....3 p.m.
*Deceased.

Public Relations

JOSEPH HENRY KLER, *Chairman*New Brunswick
JOSEPH BERKELEY GORDON, *Vice-Chairman*Marlboro
GEORGE BARTON BARLOWEnglewood
EDGAR PARMELE CARDWELLNewark
HOMER ISAAC SILVERSVentnor
JACOB ALLEN YAGERPaterson
ELIAS JOSEPH MARSH, *Consultant*Paterson

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Publication

HENRY C. BARKHORN, *Chairman*Newark
EDWARD JOSEPH ILLNewark
JAMES LAWRENCE EVANSNorth Bergen
WILLIAM JOHN CARRINGTON, *Ex-Officio*Atlantic City
ALFRED STAHL, *Ex-Officio*Newark
FRANK OVERTON, *Editor*Trenton

Meetings

Trenton.....June 5, 1938.....11 a.m.
Newark.....July 27, 1938.....4:30 p.m.
Newark.....Aug. 31, 1938.....4:30 p.m.
Newark.....Sept. 28, 1938.....4:30 p.m.
Newark.....Oct. 26, 1938.....4:30 p.m.
Newark.....Nov. 23, 1938.....4:30 p.m.
Newark.....Dec. 28, 1938.....4:30 p.m.
Newark.....Jan. 25, 1939.....4:30 p.m.
Newark.....Feb. 22, 1939.....4:30 p.m.
Newark.....Mar. 29, 1939.....4:30 p.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Scientific Exhibits

ASHER YAGUDA, *Chairman*Newark
JAMES GORDON BOYES, *Vice-Chairman*Plainfield
NICHOLAS MARK ALTERJersey City
WILLIAM WOLF HERSOHNAtlantic City
LUTHER AGUSTUS MARKLEYTeaneck
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Aug. 7, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Scientific Program

CLARENCE LADELL ANDREWS, *Chairman*Atlantic City
ROBERT SPEER GAMON, *Vice-Chairman*Camden
LOUIS CHARLES LANGEWeehawken
HARRISON STANFORD MARTLANDNewark
PAUL BRYSON REISINGERTrenton
WILLIAM JOHN CARRINGTON, *Consultant*Atlantic City

Meetings

Trenton.....Aug. 7, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Study of Sterilization

CHARLES WRIGHT MACMILLAN, *Chairman*Passaic
SAMUEL EMLEN STOKES, *Vice-Chairman*Moorestown
WALTER JOHN FARRTeaneck
THEODORE RUSSELL ROBIEEast Orange
ALFRED FREDERICK SFERRABound Brook
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Traffic Accidents

ELBERT STETSON SHERMAN, *Chairman* Newark
MILLARD FREEMAN SEWALL, *Vice-Chairman* Bridgeton
THOMAS SIMON PADDOCK FITCH Plainfield
CHRISTIAN PETER SEGARD Leonia
GEORGE JOHN YOUNG Morristown
JESSE LYNN MAHAFFEY Haddonfield
WATSON BUDLONG MORRIS, *Consultant* Springfield
ARNOLD VEY, *Technical Adviser*, representing A. W. Magee, Commissioner of Motor Vehicles of N. J. Trenton

Meetings

Trenton..... June 5, 1938.....11 a. m.
Trenton..... Oct. 2, 1938.....11 a. m.
Trenton..... Dec. 4, 1938.....11 a. m.
Trenton..... Feb. 19, 1939.....11 a. m.
Trenton..... Apr. 16, 1939.....11 a. m.

Tuberculosis

ABRAHAM EZRA JAFFIN, *Chairman* Jersey City
SAMUEL BUDD ENGLISH, *Vice-Chairman* Glen Gardner
NORMAN WYVELL BURRITT Summit
LEO BERTHIER DRAKE Franklin
CLYDE M. FISH Pleasantville
MARCUS WARD NEWCOMB Browns Mills
HAROLD SIMON HATCH Morristown
JOHN EDMUNDS RUNNELLS Scotch Plains
HARRY BURTON WALKER Vineland
FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton..... June 5, 1938.....11 a. m.
Trenton..... Oct. 2, 1938.....11 a. m.
Trenton..... Dec. 4, 1938.....11 a. m.
Trenton..... Feb. 19, 1939.....11 a. m.
Trenton..... Apr. 16, 1939.....11 a. m.

Venereal Disease Control

CHARLES BYRON BLAISDELL, *Chairman* Long Branch
MARSHALL DAVIS HOGAN Boonton
BAXTER ALFONSO LIVENGOD Swedesboro
STANLEY MARTIN MCGEEHAN Atlantic City
ROBERT RAYMOND SELLERS Newark
STANLEY R. WOODRUFF Jersey City
WILLIAM FRANCIS COSTELLO, *Consultant* Dover
ARTHUR JAY CASSELMAN, *Technical Adviser*, representing Dr. Jesse Lynn Mahaffey, Director of N. J. Dept. of Health Camden

Meetings

Trenton..... June 5, 1938.....11 a. m.
Trenton..... Oct. 2, 1938.....11 a. m.
Trenton..... Dec. 4, 1938.....11 a. m.
Trenton..... Feb. 19, 1939.....11 a. m.
Trenton..... Apr. 16, 1939.....11 a. m.

Welfare

HILTON SHREVE READ, *Chairman* Ventnor
WILLIAM JOHN CARRINGTON, *Ex-Officio* Atlantic City
ALFRED STAHL, *Ex-Officio* Newark
DAVID BACHARACH ALLMAN Atlantic City
FRANK WILLIAM ASH Paterson
GEORGE BARTON BARLOW Englewood
FRANK A. BIEN Irvington
ARTHUR WALTER BINGHAM East Orange
CHARLES BYRON BLAISDELL Long Branch
WENDALL JONES BURKETT Pitman
NORMAN WYVELL BURRITT Summit
EDGAR PARMELE CARDWELL Newark
HARRY NOAH COMANDO Newark
MARCUS ALBERT CURRY Greystone Park
WALTER JOHN FARR Teaneck
FRANK L. FIELD Far Hills
GEORGE WASHINGTON FITHIAN Perth Amboy
JACOB IRVING FORT Newark
BARCLAY STOKES FUHRMANN Flemington
GEORGE B. GERMAN Camden
JOSEPH BERKELEY GORDON Marlboro
DAVID WRIGHT GREEN Salem
DANIEL LEO HAGGERTY Trenton
DONALD OSBORN HAMBLIN Bound Brook
HENRY HAYWOOD New Brunswick

EUGENE GARFIELD HERBENER Lakewood
WILLIAM GETTIER HERRMAN Asbury Park
ERNEST GARFIELD HUMMEL Camden
ALLEN GILBERT IRELAND Trenton
ABRAHAM EZRA JAFFIN Jersey City
SIGURD WALTER JOHNSEN Passaic
ROBERT ANTHONY KILDUFFE Atlantic City
JOSEPH HENRY KLER New Brunswick
ISAAC WARNER KNIGHT Pitman
FREDERIC WILLIAM LATROP Plainfield
JULIUS LEVY Newark
CHARLES LITWIN Teaneck
JOSEPH FRANCIS LONDRIGAN Hoboken
CHARLES WRIGHT MACMILLAN Passaic
JACOB JOHN MANN Perth Amboy
WILLIAM WALLACE MAVER Jersey City
CHARLES HENRY MITCHELL Trenton
BARCLAY WELLINGTON MOFFAT Red Bank
HERSCHEL STRATTON MURPHY Roselle
LESLIE EDWIN MYATT Bridgeton
STANLEY HETFIELD NICHOLS Long Branch
JAMES FRANCIS NORTON Jersey City
BERTHOLD STEINBACH POLLAK Secaucus
WARREN DAVID ROBBINS Cape May
MILLARD FREEMAN SEWALL Bridgeton
TRAUGOTT JOHN SCHUCK Hoboken
REUBEN LORE SHARP Camden
BYRON GRANT SHERMAN Morristown
HOMER ISAAC SILVERS Ventnor
SPENCER TREADWELL SNEDECOR Hackensack
JAMES HERBERT SPENCER, JR. Franklin
SAMUEL EMLIN STOKES Moorestown
*THEODOR TEIMER Newark
ADOLPH TOWBIN Lakewood
CHESTER ISAAC ULMER Gibbstown
HERBERT ROY VAN NESS Newark
WILLIAM HENRY VARNEY Washington
HARRY BURTON WALKER Vineland
WILLIAM CRANE WILENTZ Perth Amboy
JACOB ALLEN YAGER Paterson
GEORGE JOHN YOUNG Morristown
ANTHONY CHARLES ZEHNDER Newark

Meetings

Trenton..... June 5, 1938.....1 p. m.
Trenton..... Oct. 2, 1938.....1 p. m.
Trenton..... Dec. 4, 1938.....1 p. m.
Trenton..... Feb. 19, 1939.....1 p. m.
Trenton..... Apr. 16, 1939.....1 p. m.

Woman's Auxiliary

GUSTAV AUGUST BRAUN, *Chairman* Newark
WILLIAM KING CAMPBELL, *Vice-Chairman* Long Branch
LOUIS FEINSTEIN Atlantic City
GERALD ELLSWORTH McDONNEL Mt. Holly
JOSEPH ROWLETT MORROW Ridgewood
ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Meetings

Trenton..... June 5, 1938.....11 a. m.
Trenton..... Apr. 16, 1939.....11 a. m.

Workmen's Compensation

HARRY NOAH COMANDO, *Chairman* Newark
JOSEPH FRANCIS LONDRIGAN, *Vice-Chairman* Hoboken
WILLIAM KLIPSTEIN HARRYMAN Hackensack
V. EARL JOHNSON Atlantic City
HENRY HOWARD KESSLER Newark
CEDRIC C. CARPENTER Summit
FREDERICK WILLIAM SHAFER Camden
DANIEL F. FEATHERSTON Asbury Park
ANDREW FRANCIS MCBRIDE, *Consultant* Paterson
STEPHEN J. LORENZ, *Technical Adviser*, representing J. J. Toohey, N. J. Dept. of Labor Trenton
ROY GRIFFITH, *Technical Adviser*, representing the Manufacturers' Association of N. J. Glen Ridge

Meetings

Trenton..... June 5, 1938.....11 a. m.
Trenton..... Oct. 2, 1938.....11 a. m.
Trenton..... Dec. 4, 1938.....11 a. m.
Trenton..... Feb. 19, 1939.....11 a. m.
Trenton..... Apr. 16, 1939.....11 a. m.

GAUCH, WILLIAM, Newark, General Chairman of the Local Committee on Arrangements for the Clinical Meeting of the M. S. of N. J.
HERRMAN, WILLIAM GETTIER, representing the M. S. of N. J. on the Board of Trustees of the Hospital Service Plan of N. J.
* Died Oct. 12, 1938.

WOMAN'S AUXILIARY

President, Mrs. DON A. EPLER, 45 Hillside Avenue, Newark, N. J.; Tel. Bigelow 3-7231

President-Elect, Mrs. G. E. McDONNELL Mt. Holly
First Vice-President, Mrs. A. E. JAFFIN Jersey City
Second Vice-President, Mrs. E. R. MULFORD Burlington

Recording Secretary, Mrs. BANKS S. BAKER Camden
Treasurer, Mrs. T. P. CONAGHY Camden

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County	President	Secretary	Reporter
ATLANTIC	James H. Mason, Atlantic City...	J. Carlisle Brown, Atlantic City..	E. H. Nickman, Atlantic City
BERGEN	Chester A. King, Oradell	G. Barton Barlow, Englewood	LeRoy W. Black, Rutherford
BURLINGTON ..	F. D. Fahrenbruch, Mt. Holly....	E. Warren Rodman, Beverly'	Carlton P. Hogan, Burlington
CAMDEN	H. Wesley Jack, Camden	George B. German, Camden	Harold D. Barnshaw, Camden
CAPE MAY	H. H. Tomlin, Wildwood	Warren D. Robbins, Cape May...	Warren D. Robbins, Cape May
CUMBERLAND.	Dare Woodruff, Vineland	H. S. Branin, Millville	E. S. Corson, Bridgeton
ESSEX	David A. Kraker, Newark	Marcus H. Greifinger, Newark ...	Paul H. Hosp, Newark
GLOUCESTER..	William E. Crain, Woodbury	Chester I. Ulmer, Gibbstown	Henry B. Diverty, Woodbury
HUDSON	Reeve L. Ballinger, Arlington....	Thos. McG. Brennock, Jersey City.	John N. Connell, Jersey City
HUNTERDON ..	Barclay S. Fuhrmann, Flemington	E. W. Lane, Bloomsbury	E. W. Lane, Bloomsbury
MERCER	Thomas J. Walsh, Trenton.....	A. D. Hutchinson, Trenton	A. D. Hutchinson, Trenton
MIDDLESEX ..	Norman N. Forney, Milltown.....	Estelle E. Kleiber, New Brunswick	Howard Dicker, South River
MONMOUTH ..	C. Byron Blaisdell, Long Branch..	Dan'l F. Featherston, Asbury Park	O. R. Holters, Asbury Park
MORRIS	Thomas S. Thomas, Jr., Morrist'n	George J. Young, Morristown	Marcus A. Curry, Greystone P'k
OCEAN	Emanuel Sickel, Lakewood	William E. Dodd, Beach Haven ..	J. B. Henriksen, Point Pleasant
PASSAIC	Louis G. Shapiro, Paterson	J. Allen Yager, Paterson	Irving Okin, Passaic
SALEM	H. F. Suter, Pennsgrove	James S. Dunn, Salem	L. C. Hummel, Salem
SOMERSET	Edgar T. Flint, Raritan	L. C. Fritts, Somerville	Hayward F. Day, N. Plainfield
SUSSEX	James H. Spencer, Franklin	Jesse McCall, Newton	Edward K. Hawke, Newton
UNION	Henri E. Abel, Elizabeth	Lorrimer B. Armstrong, Westfield.	R. J. Walsh, Roselle
WARREN	Clyde Smith, Oxford	William F. Skinner, Washington..	H. B. Bossard, Phillipsburg

FIELD PHYSICIANS OF THE COUNTIES

County	Name	Address	Telephone
ATLANTIC	J. Carlisle Brown	101 S. Indiana Ave., Atlantic City	5-4979
BERGEN	Lyman Burnham	229 Engle St., Englewood	3-1810
BURLINGTON	F. D. Fahrenbruch	Mount Holly	237
CAMDEN	Edmund Hessert	Collingswood	607
CAPE MAY	Clarence W. Way	Sea Isle City	55
CUMBERLAND	J. S. Knowles	Millville	52
ESSEX	Alfred Muerlin	158 S. Harrison St., East Orange	Orange 5-9026
GLOUCESTER	Chester I. Ulmer	Gibbstown	Paulsboro 18
HUDSON	Joseph P. Donnelly	1 Madison Ave., Jersey City	Delaware 3-6682
HUNTERDON	P. W. Baker	High Bridge	170-R-2
MERCER	James R. Harman	824 W. State St., Trenton	3-0436
MIDDLESEX	James Grieve	88 Market St., Perth Amboy	4-1036
MONMOUTH	William Heatley	Red Bank	80
MORRIS	George L. Nicoll	Dover	180
OCEAN	Harry Ivory	Point Pleasant	212
PASSAIC	Theodore K. Graham	279 Park Ave., Paterson	Sherwood 2-9422 and 1607
SALEM	William G. Hilliard	Salem	332
SOMERSET	Samuel H. Pogoloff	Manville	Somerville 1228
SUSSEX	August H. Groeschel	Sussex	240
UNION	Arthur E. Tator	57 DeForest Ave., Summit	6-0313
UNION (Colored)	C. DeFreitas	423 W. Fourth St., Plainfield	6-5332

S.M.A. - FOR INFANTS DEPRIVED OF BREAST MILK



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1928

When diluted according to directions, S.M.A. closely resembles human milk, *NOT ONLY* in the percentages of protein, fat, carbohydrate and ash, *BUT ALSO* in the chemical constants and in physical properties.

When fed to infants as a supplement, complement or as a complete substitute for breast milk, S.M.A. consistently produces excellent nutritional results comparable to those obtained with normal breast-fed infants.

The quick, easy method of preparing S.M.A. feedings is unusually simple. A Minute Mix Method Set together with complete directions will be sent Free to physicians on request.



S.M.A. is a food for infants . . . derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants and in physical properties.

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PROFESSIONAL LIABILITY PROTECTION

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NEW JERSEY

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What Type of Formula Agrees with the Newborn?

INFANT
FEEDING
PRACTICE
POINTERS

Answers to Physicians' Questions

1. Q. What is the composition of a whole milk formula for the newborn?

A. *Whole milk, 10 ozs. Boiled water, 10 ozs. Karo Syrup, 2 tablespoons.*

2. Q. What is the composition of an evaporated milk formula for the newborn?

A. *Evaporated milk, 6 ozs. Boiled water, 12 ozs. Karo Syrup, 2 tablespoons.*

3. Q. What is the composition of an acid milk formula for the newborn?

A. *Lactic acid milk, 12 ozs. Boiled water, 8 ozs. Karo Syrup, 2 tablespoons.*

The nutritional requirements are met by simple mixtures of cow's milk, sugar and water when the newborn is deprived of breast milk. Infants with good digestive capacities tolerate whole milk mixtures and those with low digestive capacities tolerate evaporated, dried and acid milk formulas.

But any of these milks can safely be modified with Karo. It is adapted to every type of formula devised for young infants. The amount of Karo added is usually one-third of the total required calories. Karo provides a large proportion of dextrin with relatively small amounts of maltose, dextrose and cane sugar.

*"Infants Thrive
ON
Karo Formulas"*



Infant feeding practice is primarily the concern of the physician; therefore, Karo for infant feeding is advertised to the Medical Profession exclusively. For further information, write Corn Products Sales Company, Dept. SJ-1, 17 Battery Place, New York City, N. Y.

YOU CAN SAFELY RECOMMEND
COLD INDIAN SPRING WATER

SOFTTEST OF ALL WATERS

ANALYSIS ON REQUEST

BOTTLED AT THE SPRING

**Kepwel
Spring Water Company**

1 PARK PLACE, PASSAIC

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Telephone PASSaic 2-0073

Telephone Asbury Park 1249

**IMPROVE YOUR RESULTS
IN CANCER OF THE CERVIX**



CONSISTENTLY high percentages of 5-year cures in Carcinoma of the Cervix are reported by institutions employing the French technique illustrated here. Ametal rubber applicators encase the heavy primary screens and provide ideal secondary filtration to protect the vaginal mucosa. Radium or Radon applicators for the treatment of Carcinoma of the Cervix and provided with Ametal filtration are available exclusively through us. Inquire and order by mail, or preferably by telegraph or telephone reversing charges. Deliveries are made to your office or hospital for use at the hour you may specify.

THE RADIUM EMANATION CORPORATION
GRAYBAR BUILDING Tel. MOhawk 4-6455 NEW YORK, N. Y.

A Report on the Usefulness of L. Acidophilus in Constipation of Children

THE effects of Acidophilus Milk on childhood constipation were observed recently in a study in Bridgeport, Connecticut, conducted co-operatively by the Department of Bacteriology of Yale University and the Bridgeport City Dispensary.

27 children ranging in age from 10 months to 13 years who had failed to respond to other treatment for constipation were selected for the study.

They were given one pint of Acidophilus Milk daily for at least 12 weeks.

After a rest period of 2 to 4 weeks, if the condition recurred, treatment was resumed.

Of the 27 children given the Acidophilus Milk treatment, 81% reacted favorably.

64% of those children reacting favorably became "implanters." That is, they carried L. Acidophilus in large numbers in their intestines for 16 to 20 weeks after treatment.

The complete findings of this test were published under the title, "The Therapeutic Application of Acidophilus Milk in Constipation of Children," appearing in the *American Journal of Digestive Diseases*, Vol. 5, pp. 170-173, May, 1938.

For a free reprint, write Walker-Gordon Laboratories, Inc., Plainsboro, New Jersey.

• Walker-Gordon Acidophilus Milk is cultured from pure, fresh Walker-Gordon Certified Milk, under strict scientific supervision. It contains approximately five hundred million L. Acidophilus organisms per c.c. at time of bottling. Cultures are made from a highly *viable* strain of *human* origin. Where Acidophilus milk treatment is indicated, excellent results are obtained from prescribing Walker-Gordon Acidophilus Milk.

WALKER-GORDON LABORATORIES, INC.
PLAINSBORO, N. J.



FEED THAT FEVER

Stop the febrile drain on vital body tissues with supportive dietary treatment. The increased metabolism of febrile states must be balanced by increased calorie and protein intake in an easily digested, low residue diet.

COCOMALT is becoming recognized as the scientific solution to the problems of the febrile dietary. High in calories, proteins, iron, calcium, and vitamins to help rebuild "burnt out" tissues; low in fat and residue; with added malt diastase to aid digestion and rapid assimilation —

COCOMALT also helps stimulate lagging appetites. Being highly palatable, it is likewise an excellent vehicle for milk.

The logical dietary management is FEED THE FEVER—the logical food is COCOMALT.

A FOOD... never advertised as a pharmaceutical or sedative. Indicated in the diet of the growing child—pregnant and lactating mother—the malnutritional patient—pre- and post-operative patient and in convalescence and chronic diseases.

R. B. DAVIS COMPANY
Hoboken New Jersey

Please send me a clinical
package of COCOMALT.

M.D.

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City _____ State _____

DEPT. V-1



COCOMALT malted food drink is fortified with calcium, phosphorus, iron and Vitamins A and D. Mixed with milk, it produces a delicious, nourishing drink.

R. B. DAVIS CO.
HOBOKEN, NEW JERSEY

RECENT ADVANCES IN THE SCIENCE OF NUTRITION

V. Factors Affecting the Vitamin C Contents of Foods

● Recent development of the chemical method for estimation of ascorbic acid (1) has permitted more thorough study of factors determining the vitamin C contents of foods. Circumspectly used, the 2, 6 dichlorophenol-indophenol or "indicator" titration method for vitamin C determination has proven an invaluable tool in this phase of research.

It is now apparent that the vitamin C content of food at the time of consumption is conditioned, first, by the initial ascorbic acid content of the food at the time of harvesting, and second, by the treatment to which the food is subjected between the time of harvesting and the time of consumption.

The initial vitamin C level in raw foods has been found to depend on factors such as variety, maturity and growing conditions (2). Under usual conditions of food crop production, such factors are only partially subject to human control. However, the factors influencing vitamin C in foods from harvesting until consumption are capable of closer regulation by man.

For example, it is known that long storage at improper temperatures adversely affects the initial ascorbic acid contents of foods. Even at refrigeration temperatures raw foods may lose substantial amounts of vitamin C during storage. Rough handling—which causes rupture of vegetable tissue—is also conducive to vitamin C loss especially when followed by improper storage. Certain metals will catalyze vitamin C destruction and even commonly used home-

cooking methods are attended by losses of this essential dietary factor (2).

Briefly, preservation of vitamin C in foods between harvesting and consumption is essentially a problem of preventing or reducing oxidation, either enzymatic or atmospheric. In addition, physical or solution losses must be minimized in preparation of the food for the table. It is pertinent to note that modern commercial canning procedures are well adapted to control both these chemical and physical losses of vitamin C (3).

The use of prime raw stock and quick transport to the cannery after harvesting; rapid inactivation of enzymes through heat treatment; and large scale automatic operations with minimal exposure to air, are basic practices common to all modern canning procedures. All serve to check oxidative losses of the initial ascorbic acid present in raw foods. In addition, during canning, the foods are cooked by the heat process while contained in the sealed can. The liquid within the can, therefore, retains vitamin C which has been removed from the food by solution.

Researches have shown that many commercially canned foods are to be listed among the most valuable contributors of vitamin C to the diet of the American people (2, 3, 4). Such findings demonstrate the effectiveness of modern commercial canning procedures in preservation to the highest practical degree of the initial vitamin C contents of foods.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

- (1) 1932. Ztschr. f. Untersuch. d. Lebensmitt. 63, 1.
1933. J. Biol. Chem. 103, 687.
(2) 1935. J. Amer. Med. Assn. 111, 1290.

- (3) 1932. Ind. Eng. Chem. 24, 650.
(4) 1938. J. Amer. Med. Assn. 110, 650.
1937. Bull. 19-L Nat'l. Cannery Assn., Washington, D. C., 4th Ed.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-fourth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

**ADJUNCTIVE
THERAPY**



Buffer with Kalak

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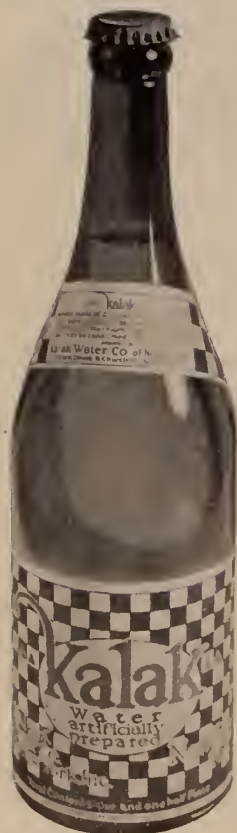
As a valuable aid to sulphanilamide therapy, physicians are prescribing Kalak because

1. It maintains the urine at the desired pH for optimum results (around 7.4).
2. It is ideally suited for inhibiting such untoward symptoms as gastric upset, skin rash, weight loss.

Kalak presents in a palatable, carbonated solution properly balanced proportions of buffer salts which do not increase motility in the intestinal tract. Kalak is not a laxative.

The Kalak formula presents in palatable, carbonated solution

Di-Sodium Phos. Crys. U.S.P.....	309.1 parts per million
Potassium Chloride.....	117.6 parts per million
Sodium Chloride.....	606.0 parts per million
Sodium Bicarbonate.....	5793.0 parts per million
Calcium Bicarbonate.....	770.6 parts per million
Magnesium Bicarbonate.....	101.2 parts per million



*Palatable
Sparkling
Neutralizing*

Kalak affords a useful adjunct to salicylate, iodide medication, etc.—increases tolerance, enhances the therapeutic effect.

KALAK WATER CO. OF NEW YORK, INC.

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*Bender & Blanchard, *Jl. Med. Soc. N. J.* 35:551, 1938.

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—IRVING, NEW YORK STATE JOURNAL OF MEDICINE,
JAN. 15, 1938.

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—NEW YORK STATE JOURNAL OF MEDICINE, JAN. 15, 1938

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—HINSHAW, JOURNAL-LANCET, AUGUST 1937.

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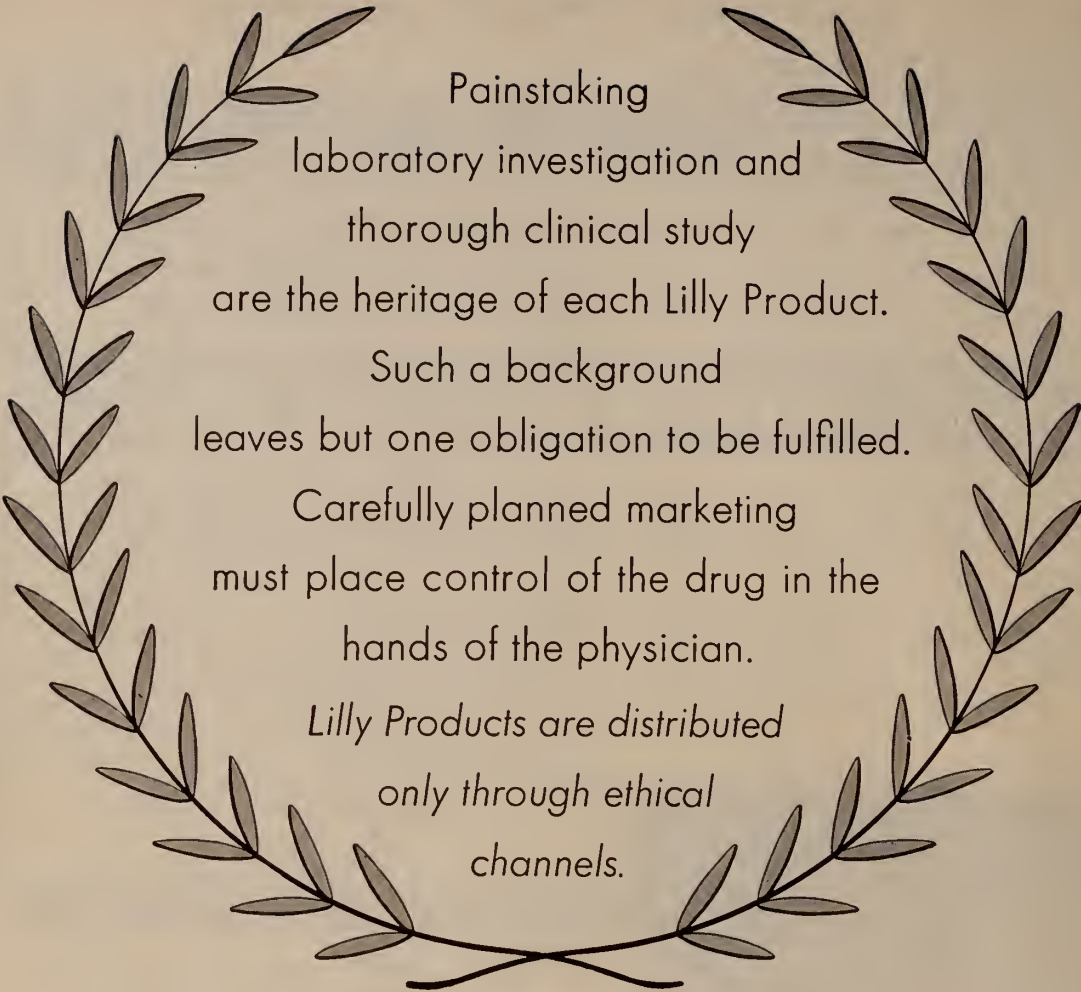
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EDITORIALS

Administrative Offices of County Societies

Several complaints have reached the Executive Offices from *new officers* that they have not been notified of certain activities carried on by the Society. Upon investigation we usually find that the fault is due to the fact that the officer or committee chairman who is retiring *has not conveyed to his successor* the complete correspondence and records received during his administration.

Maintaining files of correspondence and instructions in the office of the Secretary is not merely for the convenience of his successor;—it is for the immediate benefit of the Secretary himself. The Secretary attempts a task that is both needless and impossible when he tries to carry the details of his office in his mind. A simple letter file with alphabetical partitions is the unit,—one a year for a small society, and two or more for a larger one.

The Executive Office of the State Society has each piece of material that is sent out recorded as follows: The number sent, the date, the name to whom sent, and how much postage, and how it was sent, whether by registered mail, straight mail, or special delivery. It is

desirable that every county society institute the same or a similar system.

Increasingly it becomes evident that further developments of the integration of effort between county society officers, their members, and their committees, and those of the State Society, hinges upon the executive accomplishments of the office, rather than upon the members' professional activities.

The biggest claim for industrial medicine, hospital, school medical inspection, institutional treatment, clinics and dispensaries, and other forms of what is undoubtedly included in this ambiguous term "State medicine", lies primarily in the lack of organization of the offices of the county societies, and of the absence of executive supervision and direction of their local activities. Each society should develop the business machinery for the efficient, wide and economical distribution of professional services. Undoubtedly, there is much room for improvement in this aspect of medical service; and each county should make its own contribution in up-to-date organization as soon as possible.

Medical Civics

The equitable distribution of the services of medicine requires that physicians, as well as those who administer the services of welfare and relief, should be *civic-minded*.

Physicians are already highly skilled in the practice of *physic*, using the term in its time-honored sense to include all forms of *scientific medicine*, or the healing art. Even the severest critics of the present individualistic system of practicing medicine admit that the greatest need is not more scientific knowledge, but provision by which every sick person may obtain and carry out the advice of his doctor. Practically every physician today is willing and anxious, as well as able, to diagnose and prescribe for ninety-five per cent of the common ailments of mankind, as the late Dr. Frank Billings, of Chicago, showed twenty-five years ago. The great defect in the present system of medical practice is the patients' own lack of means,—and often the understanding,—for carrying out the medical advice which they receive; and for supporting their families during the sickness. These needs would still exist even if every family doctor were an Osler. Hence, the community has a responsibility for *supplementing* the purely medical services that are rendered personally by the physician in private practice.

ECONOMICS OR CIVICS?

Most plans, both local and national, for community participation in the care of the sick have been in the narrow field of *economics* or finan-

cial relief—which often is only a primitive form of *charity*, enforced by law or political influence. The Medical Society of New Jersey is now actively engaged in developing a working plan for the efficient distribution of medical and allied services to the needy classes, based on the broad principles of *civic action*. The plan involves a cordial coöperation between the family doctor, and the civic-social agencies that are ready to serve his patient.

No one knows better than the family doctor what services are needed to supplement his own; and he is the person that is best qualified to give advice regarding the particular forms of assistance that a patient needs—economic and social, as well as medical. A general plan of medical relief cannot be *imposed* upon the doctors. The success of any plan of medical service will depend upon the initiative and spontaneous participation of the family doctor who adapts his prescriptions and welfare advice to individual patients according to their needs.

The success of the medical division of the Emergency Relief Administration in 1934 and 1935 was the result of the coöperation of the medical societies with other organizations engaged in the work of relief. The present harmonious conferences of The Medical Society of New Jersey with the representatives of civic and welfare organizations is prophetic of the development of satisfactory agreements between all groups concerned with the distribution of medical and allied services in New Jersey.

The A. M. A. Survey of Medical Care

The A. M. A., with the approval of its State delegates and Board of Trustees, has assumed the responsibilities of leadership in a comprehensive survey of all forms of medical service throughout the nation. The deductions and recommendations made from the results of this survey may be of vital importance to each physician.

The practice of medicine is becoming increasingly socialized, and more and more under

government supervision and guidance. That further changes, necessitated by changing social conditions, are to be made is almost a foregone conclusion. If the coming changes are to be made with the coöperation and endorsement of the medical profession, it behooves us as medical societies, medical institutions, individuals, and subordinates, to give our leaders our loyal, sincere, and coöperative support and assistance.

Returns on this survey are coming in very slowly. Only one county society in New Jersey has received enough returns from the doctors, the hospitals, and other sources, to warrant submission of the requested summary.

The first series of I F forms received at this office show very few "remarks" under Para-

graph III. This is the place to state your constructive criticisms, or to suggest changes you feel may benefit you or the people of your community. If you are satisfied with present conditions, and believe the people of your community are receiving proper care, say so;—*Please say something.*

Why Pick Fault With the Medical Profession?

The proponents of the medical aspects of the Social Security Law base their proposals on the alleged failure of practicing physicians to provide efficient medical services to a large proportion of people; and in support of their attitude they advance a four-fold argument based on insufficient grounds:

1. Surveys, nation-wide and costly, have shown that over one-third of the people of the United States are not receiving efficient medical care.

2. Medical science and art is in such an advanced stage that it can prevent or cure over 90 per cent of the physical ills of mankind.

3. The principal reason that people do not receive this efficient treatment is their low financial condition.

4. The remedy proposed is to supply the medical services at public expense.

THE SERVICES OF EDUCATION

Let us compare the services of medicine with those of education.

1. The principles of the service and art of teaching are accepted as universally as those of the healing art.

2. Teachers practice their science and art as devotedly as physicians practice theirs.

3. For many years the government has supported and controlled an expensive system of compulsory education for all children up to the age of fourteen or fifteen years.

An accurate survey of four million young men was made by skilled army officers during the World War;—and what were the findings?

The average mental age of the soldiers who were accepted for service was found to be fourteen years. This meant that one-half, or two million, of the soldiers were mentally unfit to perform a soldier's services, except menial

duties, even when they were directed by skilled officers.

What is the interpretation of these statistics?

FACTS AND WISDOM

Education consists of two distinct factors:

1. *A knowledge of facts.*

2. *Wisdom* in applying facts in daily life.

The complexities and needs of modern life are such that a man having a minimum amount of knowledge of *facts* may earn an independent living and be a useful citizen, provided he has *wisdom* to make use of the meager facts which he knows. The deficiency of the dependent classes,—the indigent and the near indigent,—is their lack of *wisdom* rather than of knowledge.

SCHOOL TEACHERS AND PHYSICIANS

The defect in popular education cannot be laid primarily at the door of the teachers;—the defects are the result of the natural inability of the pupils to acquire *wisdom*.

Every physician is a teacher of health to his patient. As long as a patient of the dependent class is helplessly sick, he is willing and anxious to do as his physician tells him; but when he has recovered a degree of strength, he often lacks the *wisdom* to continue to act on the advice which his physician gives to him. This fact applies to the rich as well as to the indigent.

Judged by the test of ability to impart wisdom, the family doctor compares favorably with the school teacher, but to make a sweeping condemnation of physicians for the lack of wisdom shown by their patients in following their advice is as wrong as a similar condemnation of school teachers.

COMMUNITY HELPFULNESS

Physicians agree that the community should make provision by which those of low incomes and the indigent may obtain medical services. However, there is this difference: While children generally attempt to apply the lessons of the school, adults who are chronically below par in body or mind are not inclined to change their unhygienic habits even on the advice of their physician-teachers. Still, the dependent

classes are to a great extent the wards of the community; and the strong should bear some of the burdens of the weak who are afflicted with sickness and defects both physical and mental.

The organized medical profession is the expert consultant to the community, and is ready to do its part in the efficient distribution of medical services.

Scope of Function

The proper *scope of function* of the practitioner of medicine needs to be definitely determined and clearly stated.

The physician is a professional adviser,—not a policeman,—to individuals regarding their personal health, but in community health projects he acts as a member of the organized medical profession. As a delegated representative of his profession, he will carry out his assigned rôle in the coöperative plans which are approved by his society; and he will follow the instructions and plans of the elected and appointed leaders. He will express his individual opinion in the meetings of his Society, but when the Society has made a definite decision, he will abide by it.

The monthly *Journal* of The Medical So-

ciety of New Jersey is the means of informing the members of the standards and decision of the State Society and its component county societies. An understanding of what his confreres think and how they act is necessary in order that a member may act in harmony with his colleagues. Self-interest must always be carefully considered by the doctor; but he will find it to his own interest to adopt his ways to those of his fellow workers.

While organized medicine must determine all professional practice procedures, the help of welfare groups, business executives, government administrators is essential in carrying on community programs. Governor Moore is acting in accordance with that principle in calling a conference of leaders to advise him how to plan to meet the health needs of the State.

Calling a Doctor

At least once a week the Executive Offices get a call from some new-comer or local resident who is in need of services of a physician, for guidance in selecting a family physician.

These calls come to the office of the State Society because, in the telephone directory, there is a definite telephone number listed under the Society's name; and this to the person calling is the most authoritative source of guidance in the selection of a family physician.

The policy of the State Society in answering calls for a doctor is to refer them to the County Society; but in an emergency it names several physicians in the vicinity of the inquirer. When specialists are asked for, the suggestion is made that the family physician be consulted to see if the service of a specialist is needed; and if so to advise in his selection. It is desirable that every county society should have *its name* in the telephone directory.

A LAST-MINUTE APPEAL

A letter from the Bureau of Medical Economics dated January 4th informs us that February 28th has been set as a "deadline" for returns of A. M. A. Survey Blanks to the Bureau. Please expedite your forms.

ORIGINAL ARTICLES

THE PRESENT STATUS OF SULFANILAMIDE THERAPY

By THOMAS K. LEWIS, M.D., Camden, N. J.

Read before the Section on General Medicine of the Annual Meeting of The Medical Society of New Jersey, May 19, 1938.

Meitzsch and Klarer, of Germany, in 1932, during the course of a series of experiments with azo compounds, produced a red crystalline powder as the result of a combination or fusion of hydrochloride of sulfamido with diaminoazobenzene, which was found to possess peculiar properties. In 1935 Domagk, also of Germany, found that this substance showed a selective affinity for certain forms of streptococci, and demonstrated its efficiency, experimentally, on mice that had been infected with hemolytic streptococcus. These findings were confirmed by Colebrook and Kenney in England.

Shortly thereafter Trefonel, Nilli and Bovet, in France, established the fact that the diazo linkage was not essential, and that the parent substance, which we know as *sulfanilamide* or *prontylin*, a colorless compound, was just as effective in its antistreptococcic propensities. After some cautious clinical trials on human subjects and animal experimentation for checking toxicity, this new drug was seized upon with avidity by the medical profession of the whole world, with the result that within a very short space of time it was in general use.

Originally it was believed to be active chiefly in infections due to hemolytic streptococci of the beta type. Later it was found to be effective also in combatting infections due to other strains of streptococci and certain gram-negative cocci. Its use has spread until at the present time its use is being advocated in an ever-enlarging group of conditions such as puerperal fever, erysipelas, hemolytic streptococcus septacemia, streptococcic sore throat, gonorrhea, streptococcic meningitis, menengococcic meningitis, Type III pneumonia, and various infections of the urinary tract.

Sulfanilamide is the non-proprietary designation which has been given this drug by the

Council on Pharmacy and Chemistry of the American Medical Association, the chemical name for which is *para-aminobenzen-sulfonamide*. It appears on the market under the following proprietary names: Prontylin (Winthrop I, Prontosil Albumen (Bayer), Stramid (Alba Chemical Co.), Streptocide (Evans Sons, Lescher and Webb of London), Sulfamidyl (Abbott), Sulfonamid P. (Burrows, Welcome Co.) and Rubiazol (a French product).

EXPERIMENTAL DATA

There is a slowly accumulating mass of trustworthy experimental data, some of which it will be worth alluding to. Gay and Clark, of New York, in a series of experiments, have demonstrated that experimentally produced hemolytic streptococcic empyema in rabbits, which ordinarily proves rapidly fatal, can be aborted or greatly retarded by the administration of large subcutaneous doses of sulfanilamide. Though the exact nature of the antibacterial action of the drug is not fully understood, yet there is sufficient evidence to point to the fact that the action is exerted directly against the organism, and not through stimulation of fagocytosis or any metabolic process on the host.

Absorption of sulfanilamide from the gastrointestinal tract is extremely rapid, being completed in about four hours. In experiments on dogs it has been determined that blood concentration is no quicker after hypodermic injection than when the drug is given orally.

Marshall, of Baltimore, has demonstrated that, after absorption, the drug is found in almost uniform concentration in all the tissues of the body. Other investigators have shown that, when given by mouth, the quantity in the

cerebro-spinal fluid is somewhat less than in the blood, yet there is a considerable and an effective degree of concentration.

Marshall has also established the fact that elimination is largely by way of the *kidneys*, and that the rate is comparable to that of urea elimination; although of that quantity filtered out of the blood a large percentage may be reabsorbed during the passage of the urine through the tubules. When large doses are administered and a state of saturation has been attained, as much as 100 per cent of the daily dose may be eliminated by the kidneys. Elimination is reduced in the presence of damaged kidneys.

There has been considerable controversy as to the relative merits of sulfanilamide and prontosil, the combined form of sulfanilamide. Fuller, in an article in the *Lancet*, maintains that prontosil itself is inert, and depends for its action upon a break down into sulfanilamide. He states that, weight for weight, sulfanilamide is six times as efficient as prontosil. The only possible advantage that prontosil can have is in its greater stability which permits of its being prepared in ampules for parenteral administration.

UNTOWARD AND TOXIC EFFECTS

Those noted have been many and varied. Among the minor symptoms are occasional febrile reactions, dizziness, anorexia, nausea, vomiting and transient optic neuritis, all of which clear up with discontinuance of the drug.

Acidosis has resulted from the administration of large doses. As a prophylactic measure against this it has been suggested that sodium bicarbonate be prescribed concomitantly when large dosage is indicated.

Cyanosis and sulfhemoglobinemia have been encountered a number of times and, apparently, are due to the coadministration of sulfates, particularly magnesium sulfate. Sulfhemoglobinemia differs from methemoglobinemia in that it clears up much more slowly, and may quickly reach an alarming stage. Oxygen is of no value; and in severe cases, transfusion offers the only possible means of saving life. In the present state of our incomplete knowledge of the exact effect of various combina-

tions of sulfanilamide with other remedies it is strongly recommended that no other drugs be used, excepting sodium bicarbonate, during the course of sulfanilamide administration.

Agranulocytosis and hemolytic anemia have been reported by a number of physicians as sequellae of sulfanilamide therapy. Accordingly it is suggested that frequently repeated blood pictures should be taken during the course of treatment.

From a large number of sources come reports of *skin eruptions* following the use of sulfanilamide. The lesions encountered are maculo-papular in type and are accompanied by severe itching. At least one hemorrhagic case has been reported. The distribution of these skin lesions is largely confined to those portions of the body exposed to the sun. There seems to be sufficient evidence to warrant the opinion that sulfanilamide, plus sunlight, is the causative combination. As an added factor other writers have suggested, and there is a general growth of opinion, that there may be an element of allergy in the production of these skin eruptions.

The dosage at the present time has not been definitely determined. Dees and Colston advocate the following system: Give in four daily doses, 4.8 gms. for two days, 3.6 gms. for three days; and 2.4 gms. for the next four to eight days. Other authors advocate a reverse method, probably safer in view of possible sensitivity, namely: Give in four daily doses 1.2 gms. for two days, 2.4 gms. for two days and 4.8 gms. the next several days, provided no unfavorable reactions have appeared.

RESULTS OF SULFANILAMIDE TREATMENT

Puerperal hemolytic streptococcal infections, according to Gibbard, of England, have shown favorable response to sulfanilamide therapy; and during the short time in which it has been in general use, the mortality rate has been definitely reduced. With true British conservatism he states that he does not know whether this reduction is due to sulfanilamide, or whether it might be due to a reduction in the virulence of the infecting organism. However, as time goes on, an increasing number of reported cures are finding their way into the literature.

While one is not willing to abandon recourse to transfusions, yet sulfanilamide does give promise of becoming an important addition to the treatment of these cases. Gibbert points out that early use of the drug seems to prevent the spread of infection into the tissues; and that after there is widespread invasion, the results are much less satisfactory.

Erysipelas.—Snodgrass and Anderson, in the British Medical Journal, report a series of 312 erysipelas cases treated in four groups as follows: (1) With ultraviolet radiation; (2) with sulfanilamide; (3) with sulfanilamide and ultraviolet radiation; and (4) with scarlet fever serum. The results were decidedly in favor of sulfanilamide.

Streptococcic Meningitis.—Martin and De-launey, in the Paris Medical Journal, report the cure of a case of purulent streptococcic meningitis with the use of sulfanilamide, and mention the fact that similar results have been obtained by some of their colleagues. Weinberg, Mellon, and Shinn, of Pittsburgh, report the cure of two cases with the same treatment. Anderson, of Minneapolis, in a survey of the subject, notes that in the whole of medical literature up to 1935 there had been reported only sixty-six cures from this disease, and up to that time the mortality rate was 97 per cent. The increasing number of cures attributed to sulfanilamide would seem to promise a marked reduction in this mortality rate.

Meningococcic Meningitis.—From Baltimore and from Knoxville, Tenn., come reports of the use of sulfanilamide in the treatment of meningococcic meningitis. In both instances the results were announced as satisfactory. The gentlemen from Baltimore stated that the results compared favorably with those obtained from the use of the specific serum.

Type III Pneumococcus Pneumonia.—Heintzleman, of Pittsburgh, in a series of cases,—one-half on sulfanilamide treatment, and one-half on ordinary routine,—reports that results were slightly favorable to the new drug, but points out the statistics are not sufficiently voluminous to be conclusive. Millet, of Hempstead, reports fall of temperature in a case of Type III pneumonia in thirty-one hours after institution of sulfanilamide treatment. With

serum for this type of pneumonia still in the experimental stage, one should keep in mind the possible use of this drug. However, if the newly developed serum proves to be as valuable as that available for most of the other types of pneumonia, there can be no justification for the continued use of sulfanilamide.

Streptococcic Sore Throat.—While there are no available statistics concerning the value of sulfanilamide in this condition, one's own experience, together with that of one's colleagues, would seem to indicate that prompt recovery and a much shortened course can be attributed to the use of sulfanilamide.

Urinary Tract.—Because of the high degree of concentration in an unchanged condition in which sulfanilamide appears in the excreted urine, it is a natural consequence that one should seek to apply it to the treatment of urinary tract infections. Imhauser, of Germany, states that it is definitely effective in *Bacillus coli* infections of the urinary tract; while Helmholtz, in this country, finds it effective in the treatment of infections due to a wide variety of organisms commonly found in the urinary tract. He states that with mandillic acid, which is active in acid urine, and with sulfanilamide, which is active in alkaline media, we have in the combination an important contribution to the list of urinary antiseptics.

Gonorrhea.—Gentre, of Washington, in a report of a hundred cases treated with sulfanilamide, gives an extremely favorable opinion as to its efficiency. He states that cures were obtained in 92.5 per cent of fresh cases, and in 88 per cent of old cases; and further, gives five days as the average duration of treatment required. In his series he encountered a long list of unpleasant symptoms, such as anorexia, nausea, vomiting, and dizziness, but contends that the more prominent these symptoms the prompter the cures. Dees and Colston, of Baltimore, experienced quick response to sulfanilamide treatment in the vast majority of cases, noted a smoother clinical course, and encountered no complications. Farrell, Lyman and Youman, of Chicago, maintain that the drug acts directly upon the infecting organisms, and is most effective when given in large dosage. Opinions gleaned at random from various clin-

ics do not seem to be so uniformly enthusiastic, for some, after what they consider a fair trial, have returned to older forms of treatment. Apparently the last word has not been heard on this subject.

There is much discussion of the use of sulfanilamide in a wide variety of conditions such as malaria, typhoid fever, rheumatic fever, etc.; but, at present, there is insufficient data to warrant discussion. Past experience calls to mind so many remedies that have come with a wave of enthusiasm, only to sink into oblivion, that one naturally looks with some skepticism at any new drug widely hailed as a panacea. However, there is sufficient reliable data to indicate that sulfanilamide has come to stay as an important addition to our pharmaceutical armamentarium, and it only remains for time and experience to teach us its limitations as well as its full value.

CONCLUSIONS AND PRACTICAL CONSIDERATIONS

1. Sulfanilamide is indicated in the treatment of infections caused by the streptococcus hemolyticus, and probably is useful in infections due to other strains of streptococcus. It is of value in the treatment of infections of the urinary tract due to bacillus coli, and probably in several other infections including gonorrhea. It should not be considered in preference to any established specific treatment.

2. Use of sulfanilamide should be based upon precise etiologic diagnosis. Its careless administration as a panacea in the treatment of a wide variety of infections is both reprehensible and dangerous.

3. Sulfanilamide should never be administered in conjunction with sulfates, in particular with magnesium sulfate. Until its combining action with other drugs and chemicals within the body has been thoroughly investigated, it would seem advisable not to give it concurrently with any other medication, excepting *sodium bicarbonate*.

4. When prescribing the drug in massive dosage, or in small dosage over a long period of time, frequently repeated blood examinations should be made as a safeguard against the possible development of agranulocytosis and hemolytic anemia.

5. Even though animal experimentation seems to indicate an extremely low degree of toxicity, nevertheless, except when dealing with acute serious illness, it is advisable to hold to low dosage.

6. Patients taking sulfanilamide should be warned against exposure to strong sunlight.

7. It is advised that non-proprietary sulfanilamide be prescribed. Certainly no proprietary preparation should be used until it has been thoroughly tested by some reliable and responsible agency.

THE TREATMENT OF INFECTIONS OF THE CENTRAL NERVOUS SYSTEM, WITH SPECIAL REFERENCE TO SULFANILAMIDE

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From the Bureau of Laboratories, Department of Health, New York City. Read before the Pediatric Section of The Medical Society of New Jersey, May 18, 1938.

The acute infections of the central nervous system may be divided into those due to *viruses* and those due to *bacteria*.

The principal diseases due to viruses are poliomyelitis, various forms of encephalitis, choriomeningitis, and a condition which is, I believe, rather rare, the *Guillain-Barré syndrome*. Experimentally there have been no favorable results with sulfanilamide in the treatment of any of these acute infections with

the exception of choriomeningitis (Rosenthal¹).

It will be difficult to prove this clinically, as patients presenting the symptoms of lymphocytic choriomeningitis usually recover before the diagnosis is established by laboratory work.

While the use of *sulfanilamide* will be the chief topic of discussion in this paper, the title evidently calls for a brief reference to other forms of treatment.

TREATMENT OF POLIOMYELITIS

Acute poliomyelitis is, in my opinion, best treated by complete rest, and lumbar punctures as indicated for the relief of pressure. Great care should be taken in performing lumbar punctures in cases of the bulbar type of poliomyelitis, and especially in those cases characterized by marked asthenia. It is well in both these types to rely mainly on intravenous injection of hypertonic glucose for the relief of pressure. If weakness or paralysis develops, splints, pads, or casts must be used to prevent the stretching of the weakened muscles, with its resulting deformity. Indeed, at the earliest appearance of paralysis, the patient should be under the care of a competent orthopedist. With proper and prolonged treatment by an orthopedist and physiotherapist, quite a remarkable return of function may be expected. The use of convalescent serum in the preparalytic stage of poliomyelitis was definitely proved to be of no value in the epidemic of 1931.

TREATMENT OF ENCEPHALITIS

Much the same treatment may be used in acute cases of encephalitis except that in this disease paralyzes are quite infrequent. As in poliomyelitis, there should be complete, and even more prolonged, rest. The Matheson Commission has been working for some years with a formalized vaccine of a neurotropic herpetic-like virus. The comparison over the last several years of the treated and untreated cases shows less than half the case fatality in the treated cases. However, we are not ready to claim any special value for the vaccine, as we think a longer study is necessary since encephalitis is so erratic in its course.

Here, in the East, there have been apparently few cases of the St. Louis type. As is well known, the treatment recommended in St. Louis was rest, lumbar puncture, and the intravenous injection of hypertonic glucose.

CHORIO-MENINGITIS

Lymphocytic choriomeningitis, caused by a virus isolated by Armstrong,² has been searched for in vain by our Division. According to the cases reported, the same form of treatment,

rest, lumbar punctures, and hypertonic glucose intravenously, has been successful.

THE GUILLAIN-BARRÉ SYNDROME

The Guillain-Barré³ syndrome is a disease with which I have been familiar for little more than a year. It is also called *neuronitis*. With the relatively few cases reported, I doubt if we know the entire clinical picture. The six cases which I have seen might, for the most part, be mistaken for poliomyelitis. However, the onset was not characteristic, the patients complaining for the most part of a dull pain or prickling sensation in the lower extremities. In at least three of the patients, paralysis began in the feet and extended rapidly upward. The fear of respiratory paralysis was so great that respirators were kept in the rooms of two of these patients. It would take too long a time to describe the symptoms fully, but the characteristic finding that, so far as we know, make the diagnosis is an increase to higher levels in the protein in the spinal fluid during convalescence; whereas in poliomyelitis, the protein decreases. The treatment of the paralysis is the same as that of poliomyelitis, and usually it responds rather quickly, and completely to treatment.

The syndrome is considered by some to be a virus infection, and by others to be an avitaminosis. Lumbar punctures have been performed as indicated, intravenous glucose has been administered, and most of the patients have received vitamin B₁.

THE SULFANILAMIDE TREATMENT

When we consider infections of the central nervous system due to bacteria, especially meningitis, we realize that sulfanilamide has quite revolutionized the treatment of certain forms of meningitis, particularly those due to the hemolytic streptococcus.

Our experience with this chemical has been largely confined to *prontosil*, *prontylin*, and more recently *prontosil soluble*, by mouth. It may be well to speak briefly in regard to these compounds.

The chemical referred to in this paper as *prontosil* (the name of which is to be changed to *neoprontosil*) is not the same as the earlier,

less soluble preparation synthesized by Mietzsch and Klarer.⁴ We agree with Brown and Bannick⁵ of the Mayo Clinic that the relation of prontosil to sulfanilamide is peculiar, and not clearly understood at the present time. As prontosil yields only eleven grains (0.73 gm.) of sulfanilamide per 100 cc. of 2.5 per cent solution, it is difficult to believe that the satisfactory results observed after the administration of from 40 to 100 cc. daily can be distributed solely to the sulfanilamide fraction of prontosil. It would seem that prontosil is capable of producing some other chemotherapeutic action in the body. Recently Barlow⁶ reported that the oral lethal dose of prontosil in laboratory animals was nearly seven times as great as that of sulfanilamide.

Other workers report favorably on the anti-streptococcic effect of prontosil administered orally. With these statements, our experience inclines us to agree. While we have not used prontosil orally as much as prontosil and prontosil by injection, we have had rapid and remarkable improvement following the use of prontosil by mouth.

MENINGITIS

Returning now to the consideration of various forms of meningitis, one can hardly refrain from saying a few words in regard to the treatment of meningococcic meningitis (Table 1).

Our division of the Bureau of Laboratories, which has been in existence for nearly twenty-eight years, continues to believe in the moderate use of serum. We think serum should be administered only intraspinally, unless there is evidence that a meningococcemia is present, either by clinical manifestations, especially a spreading hemorrhagic or pleomorphic rash or by repeated positive blood cultures.

Experimentally it has been shown that a combination of serum and sulfanilamide is more efficacious against the meningococcus than either agent alone (Branham and Rosenthal). Schwentker⁸ and others have reported favorable results in the treatment of meningococcic meningitis by sulfanilamide only. However, we are not ready to discard the use of serum intraspinally. From a somewhat limited experience we do think that prontosil may replace the use of serum in meningococcemia. We also believe that the use of prontosil, preferably by mouth, may be a useful adjuvant to the serum in the treatment of meningococcic meningitis.

As the incidence of meningococcic meningitis in New York City has been particularly low during the last year or so, we have not had sufficient experience with the rôle that prontosil may play to give a very decisive statement. Time does not permit an extensive discussion of the treatment of meningococcic meningitis. I may say in passing that I do

	Meningo- coccus	Streptococcus	Pneumo- coccus	B. Influenzae	B. Tuber- culosis	Miscellaneous Organisms	Total
1, 2, 3 months	47	14	10	3	4	14	92
4, 5, 6 months	87	10	6	15	27	10	155
7 through 12 months..	97	4	17	25	107	21	271
Total under one year..	231	28	33	43	138	45	518
1-2 years	100	6	14	40	192	10	362
2-3 years	65	13	12	20	114	10	234
3-5 years	164	24	20	27	167	12	414
5-10 years	269	107	35	16	143	30	600
10-20 years	324	37	33	8	110	43	555
Over 20 years	401	54	102	10	133	78	778
Age not stated	12	5	6	0	13	5	41
Total	1566	274	255	164	1010	233	3502

During 1937, 147 additional cases of meningitis were seen

TABLE 1

MENINGITIS—AGE AND ETIOLOGY

not believe that the antitoxin is as valuable as the serum in the treatment of meningitis; nor do I believe in the efficacy of large doses of serum or antitoxin administered only by the intravenous route as advocated by Hoyne.⁹

In most of his reports Hoyne seems to be referring to cases in which meningococcemia appears to be the outstanding feature. Indeed, in a group of nine cases with eight recoveries, a lumbar puncture was not done to establish the presence or absence of meningitis.

During the past several years there has seemed to be in various parts of the country an unusually high percentage of cases of either meningococcemia alone, or of meningococcemia and a very mild meningitis. This certainly has been our experience for the last four or five years. The results of treating these cases with rather small doses of antimeningococcic serum has been well described by Applebaum¹⁰ of our Division.

If block occurs, we are inclined to prefer ventricular to cisternal punctures if the fontanelle is still open. Ventricular punctures are not only safer but they are likely to be more effective as the block is so often above the cistern.

The use of sulfanilamide in cases of *hemolytic streptococcal meningitis* has yielded the most revolutionary results. Before this chemical was used, the case fatality was more than 95 per cent. Since its use the case fatality has been about 20 per cent in a group of twenty-six cases. Table two shows the outstanding features. (Pages 12 and 13.)

The diagnosis in these cases was definitely established by recovery of the hemolytic streptococcus from the spinal fluid by culture. In this connection it is important to stress that certain strains of this organism hemolyze only horse blood, and in media which do not contain sugar. Unless this is borne in mind, the hemolytic streptococcus will occasionally be misinterpreted as belonging to the non-hemolytic group. Table two shows the more important points in regard to these cases.

It will be noted that of the five fatal cases, sulfanilamide was used less than twelve hours in two instances and less than twenty-four hours in a third instance. In a fourth fatal case, the

necropsy showed herniation of the cerebellum through the mastoid wound and thrombosis of the left lateral and transverse sinuses and of the left jugular vein.

These results seem to us who have been working so long and so unsuccessfully with this form of meningitis, little less than astounding. The question is sometimes raised as to the possibility that the hemolytic streptococcus may recently have become more benign. Such a radical and sudden change seems to us most improbable. During the year 1936, we saw twenty cases of this type, all of which died with the exception of one following scarlet fever, which was treated with small amounts of sulfanilamide and large amounts of convalescent serum.

In addition, we would like to refer to two cases of meningitis following otitis and mastoiditis, in which the spinal fluid was that of a meningitis, with gram positive diplococci on smear but negative cultures. Both of these patients recovered.

We have treated certain rarer forms of purulent meningitis with sulfanilamide largely on an experimental basis. These will be briefly enumerated: Three cases due to the non-hemolytic streptococcus (two of the viridans variety) with one recovery (viridans) and two deaths; four due to the staphylococcus, with one recovery (twenty-four days' old infant) and three deaths.

It has been reported experimentally that sulfanilamide combined with serum was as efficacious in certain strains of pneumococcal infections as in meningococcal or hemolytic streptococcal infections. Our clinical results have not corroborated this in pneumococcal meningitis.

PNEUMOCOCCIC MENINGITIS

Pneumococcal meningitis was uniformly fatal in our experience of nearly twenty-seven years until we began the use of sulfanilamide. Since that time we have had thirty-two cases, with four recoveries. The recoveries were types 31, 29, 4, and 13. It should be pointed out that, in several of the fatal cases, the course was prolonged, with periods of improvement. When a specific serum is available,

TABLE 2
CASES OF MENINGITIS DUE TO THE HEMOLYTIC STREPTOCOCCUS

Case	Sex	Age, Yrs.	Primary Source of Infection	Treatment	Result	Remarks
1	F	21	Right maxillary sinusitis. Right otitis with mastoiditis.	Drainage antrum; mastoidectomy, spinal drainage, sulfanilamide, convalescent scarlet fever serum.	Recovered	Only a small amount of serum was given.
2	F	7	Left otitis with mastoiditis.	Mastoidectomy, spinal drainage, sulfanilamide.	Recovered	
3	M	5½	Left otitis.	Antimeningococcic serum (4 doses), spinal drainage, sulfanilamide.	Recovered	
4	F	43	Right otitis.	Spinal drainage, sulfanilamide.	Recovered	
5	F	3½	Left otitis.	Spinal drainage, sulfanilamide.	Recovered	
6	F	11	Right otitis with mastoiditis.	Spinal drainage, sulfanilamide.	Recovered	Refused operation and mastoiditis persisted after recovery from meningitis.
7	F	2	Double otitis with right mastoiditis, following scarlet fever.	Right mastoidectomy with ligation right jugular, spinal drainage, sulfanilamide, convalescent scarlet fever serum.	Died	Meningitis appeared 7 days after operation. Necropsy showed herniation of cerebellum and thrombosis of left lateral and transverse sinuses and of left jugular.
8	M	5½	Left otitis with mastoiditis, following pneumonia.	Mastoidectomy, antimeningococcic serum, spinal drainage, sulfanilamide.	Recovered	
9	M	8	Right otitis with mastoiditis.	Mastoidectomy 1 mo. prior to meningitis, spinal drainage, sulfanilamide.	Recovered	Mastoidectomy done about 1 mo. before onset of meningitis. Spinal fluid showed positive culture for 14 successive days.
10	F	4	Left otitis with mastoiditis, and later right otitis.	Left mastoidectomy, spinal drainage, sulfanilamide.	Recovered	At operation left mastoid, found necrotic although no clinical signs.
11	M	35	Pansinusitis.	Antimeningococcic serum, spinal drainage, sulfanilamide.	Died	Sulfanilamide was used for less than 24 hours. Necropsy showed pansinusitis and sarcoma of pituitary.
12	F	12	Left otitis with mastoiditis.	Mastoidectomy, spinal drainage, sulfanilamide, 1 dose antimeningococcic serum.	Recovered	At operation, mastoid found necrotic although no clinical signs.
13	F	10 Mos.	Double otitis with double mastoiditis.	Mastoidectomy, spinal drainage, sulfanilamide.	Died	There was also clinical evidence of brain abscess. At operation, dural plate found nearly destroyed. Sulfanilamide used for less than 12 hours.

TABLE 2 (continued)

Case	Sex	Age, Yrs.	Primary Source of Infection	Treatment	Result	Remarks
14	F	8	Left otitis with mastoiditis.	Mastoidectomy, spinal drainage, convalescent fever serum, sulfanilamide.	Recovered	At operation, mastoid found necrotic although no clinical signs.
15	F	6½	Right otitis with mastoiditis.	Mastoidectomy, spinal drainage, sulfanilamide.	Died	Necropsy showed meningitis but no localized suppuration.
16	M	4	Following measles, first left otitis with mastoiditis and later right otitis with mastoiditis.	First left mastoidectomy and later right mastoidectomy, spinal drainage, sulfanilamide.	Recovered	Meningitis appeared 12 days after left mastoidectomy. At this time a right mastoidectomy done.
17	M	7	Double otitis with double mastoiditis following scarlet fever.	First left mastoidectomy and 3 weeks later, right mastoidectomy, spinal drainage, sulfanilamide.	Recovered	Onset of meningitis was about 12 days after the second mastoidectomy.
18	F	11 Mos.	Upper respiratory infection.	One spinal drainage, antimeningococcic serum, sulfanilamide.	Died	Death in less than 12 hours after receiving sulfanilamide.
19	F	6	Double otitis, double mastoiditis.	Double mastoidectomy, spinal drainage, sulfanilamide.	Recovered	
20	F	8	Chronic left otitis.	Spinal drainage, sulfanilamide orally, prontosil intramuscularly and intraspinally, mastoidectomy.	Recovered	Mastoid at operation showed granulation, but no pus. Blood culture sterile.
21	M	2	Right otitis.	Spinal drainage, sulfanilamide.	Recovered	No signs of mastoiditis.
22	M	15	Bilateral chronic otitis.	Spinal drainage, sulfanilamide, left mastoidectomy and 2 months later right mastoidectomy.	Recovered	Meningitis cleared up shortly after first operation.
23	M	7	Right otitis and mastoiditis.	Spinal drainage, sulfanilamide, mastoidectomy.	Recovered	
24	F	12	Right otitis.	Spinal drainage, sulfanilamide orally and intravenously.	Recovered	
25	F	11	Right otitis.	Spinal drainage, prontosil intramuscularly and intraspinally, prontosil orally.	Recovered	
26	F	7	Throat infection.	Spinal drainage, prontosil intramuscularly, prontylin orally.	Recovered	X-ray of sinuses and mastoid negative.

it is combined with prontosil and injected intraspinally. It has seemed to us that one reason at least that sulfanilamide has been so relatively unsuccessful in pneumococcic meningitis is that foci of infection have been so seldom located and removed. We have also seen two patients with meningitis in which the hospital reported type II pneumococcus in which recovery took place.

INFLUENZAL MENINGITIS

During the past five or six years there has been a decided increase in meningitis due to *B. influenzae*. Povitzky¹¹ found experimentally that mice were quite effectively protected against lethal doses of the strain *B. influenzae*, commonly found in meningitis, by the use of prontosil and a specific serum.

In this form of meningitis also, the clinical results have not corresponded with the experimental results. In treating this form of meningitis we have used the specific serum intraspinally; and as a bacteremia is often present, also intravenously. Recently we have been combining the serum with prontosil for intraspinal use. Sulfanilamide is given by other routes also. The results, however, have been disappointing. Out of eighteen cases only two have recovered.

The use of phage preferably, or sulfanilamide, is worthy of trial in meningitis due to organisms of the colon-typhoid group, the staphylococcus and the *B. pyocyaneus*.

MISCELLANEOUS CASES

We have also seen a certain group of cases that may be classed as miscellaneous, some with a brain abscess and a meningitis due in one case to a hemolytic streptococcus, and another due to a staphylococcus aureus, and a third to a mixed infection. In a fourth case there was a brain abscess due to *B. influenzae* without meningitis. All of these patients died. In a fifth case of brain abscess following an otitis media and a mastoiditis from which a streptococcus hemolyticus was isolated, recovery took place. This patient had had sulfanilamide during the acute otitis media and also before and following the operation on the mastoid and the abscess. The patient made a com-

plete recovery without the development of a meningitis.

DOSAGE OF SULFANILAMIDE

Altogether we have treated more than 150 cases with sulfanilamide, using, as a rule, prontosil both subcutaneously and intraspinally, prontosil by mouth, and occasionally in an 0.8 per cent solution intraspinally, and quite recently the prontosil soluble capsules orally.

We have always used a much smaller dose than has been recommended by certain authorities. In regard to dosage, it is our impression that it is not necessary to use the large doses advocated by certain workers. Indeed, recent experimental work by Osgood¹² would seem to indicate that small doses at frequent intervals are more effective than larger doses at longer intervals. As a rule, we have given five cc. or less of the prontosil solution every four hours to younger children; and ten cc. every four hours to older children and adults. In addition, from five to fifteen grains of sulfanilamide have been given every four to six hours. The same dosage was followed when giving prontosil by mouth. At present we are inclined to use prontosil orally, unless the patient cannot swallow or retain medication by mouth. Under these conditions it is given by injection. We occasionally administer prontosil intraspinally, using an equal amount of prontosil (2.5 per cent) and a specific serum if available or sterile normal saline or sterile distilled water.

It should be pointed out that the pH of prontosil is 6.8, which is compatible with its intraspinal use.

TOXIC REACTIONS

While sulfanilamide is a therapeutic agent of great value, it has also toxic qualities of no little import. The most serious toxic manifestations are those associated with the hematopoietic system, namely,—hemolytic anemia, and granulocytopenia. The development of morbilliform skin rashes and fever constitute less severe reactions. Mild toxic effects are quite common, and they include cyanosis, dyspnea, dizziness, nausea, headache, excitement, and confusion. Certain of these reactions appear to be direct toxic effects of the drug, while

others, particularly hemolytic anemia and agranulocytosis, must at present be regarded as idiosyncrasies. Fortunately, we have not encountered any of the more serious reactions.

With the development of the more severe toxic manifestations, the drug should be withdrawn at once. We do not, however, consider cyanosis as an indication to discontinue the sulfanilamide. It should be noted that the oxygen-carrying capacity of the red blood cells is not diminished during the period of cyanosis. Dyspnea, which is due to acidosis, can usually be prevented by the routine administration of sodium bicarbonate in conjunction with the sulfanilamide. When the alkali can not be given by mouth, one may administer a one-sixth normal sodium lactate solution by the intravenous or subcutaneous route.

It is important in administering sulfanilamide to make frequent, complete blood counts.

In closing, I wish to state that I consider sulfanilamide and its various compounds, especially prontosil, and prontosil soluble, one of the major achievements in chemotherapy. It has been used too short a time for us to feel certain of the best dosage and mode of administration. We do not, as yet, know the full scope of its use in various bacterial infections. We cannot look forward into the future to see what new developments may take place in the next few years, or even months. The intensive research work which is being carried on makes us quite certain that there are new and important developments yet to come.

We wish to thank the Winthrop Chemical Company for their generosity in supplying us with their preparation of sulfanilamide for clinical use.

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ROENTGEN THERAPY OF CANCER BY THE METHOD OF CHAOL

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Destruction of cancer cells depends on the selective lethal effect of the radiating beam on cancer tissue. Effective radiation dosage against cancer, however, is often of an intensity which causes irreparable damage to normal tissues. Because of this, experience and knowledge of the factors involved in the biological response to radiation are essential to successful therapy. In our efforts to improve the results of radiation therapy, the ideal attainment is obviously the complete destruction of the entire malignant tumor with the least amount of injury to the surrounding healthy tissues.

The study of the science of radiation consists, in part, of various methods to attain this ideal. The *Coutard method* of fractionated

doses has been a great improvement over the *massive dose technic*. With the Coutard method, the dose which the tissue can stand without damage is a manifold of the massive dose given at one time. When treating cancers situated at a depth from the surface it is necessary for the therapist to apply a hard, penetrating ray of high intensity, if he is to convey an effective amount of radiant energy to the tumor. In other words, the therapist must use a high voltage or high intensity beam, with which there is a high percentage depth dose. When the cancer to be treated, however, is on the surface or extends only a centimeter or so deep, or is so situated that it can be made accessible by the surgeon, there is usually no

healthy tissue on the surface to be spared. Only the normal tissue under the cancer (the so-called tumor bed) need be considered. In such cases, the dose should be great on the surface and in the tumor; but should decline sharply and be harmless in the underlying tissues. In other words, a low-voltage or low-intensity beam with which there is a small percentage depth dose is desirable.

THE DEVELOPMENT OF CONTACT OR SHORT-DISTANCE LOW-VOLTAGE ROENTGEN THERAPY

High voltage x-radiation is unsuitable in the treatment of superficial or accessible lesions because of its great destructive powers. Radium has given excellent results in superficial lesions, not because of the shorter wave lengths of its emanations, but rather because of the possible dose distribution in the tissues. The effect obtained from radium element needles or radon seeds used interstitially has approached closer to the ideal requirement. With interstitial radium or radon seeds, the source of radiation is in the tumor itself; and because of the inverse square law there is a rapid decline in the dose effect, and the surrounding tissues are damaged only to a slight degree. The use of radium, however, involves expense, complicated technics of application, and some difficulties in the protection of surrounding normal tissues. The few disadvantages of the use of radium has stimulated the search for an x-ray tube which combines the advantages of the dose distribution of interstitial radium, and the economy, efficacy, and convenience of the x-rays.

This search has been keenest in Germany, where radium is scarce and expensive. In that country, in recent years, there has developed a method known as *contact or short-distance low-voltage therapy*. This method delivers to superficial cancers doses of sufficient strength to disintegrate tumor cells, and spares the healthy surrounding tumor bed by using small fields sharply localized about the tumor. It produces a steep energy gradient which furnishes limitation of depth effect. The gradient obtained is made steep by decreasing the target-skin distance, and decreasing the voltage delivered to the tube. Since this apparatus operates at con-

tact or very short distances, it is absolutely necessary that the entire apparatus be *shock-proof*. This particular modality naturally will not supplant radium for all types of application. The results thus far obtained show that this apparatus is a valuable *supplementary* weapon.

Schaefer and Witte, of Gottingen, Germany, began their experiments in 1929, using a Lenard tube and cathode rays only, later adding a metal filter over the tube opening which does not let out any cathode beams and acts as the anode. It produces soft x-rays. They designed an apparatus which frees the patient of all electrical dangers. They were essentially interested in gynecological neoplasms. Such neoplasms involve some depth, and therefore a tube furnishing a suitable depth dose was required. The Schaefer-Witte intracavitary roentgen apparatus functions, therefore, at 90-100 kilovolts, four milliamperes, and uses a thin copper filter.

Chaul, of the Surgical Clinic of the Charite, Berlin, Germany, is of the opinion that the superior results of radium in the treatment of superficial or intracavitary cancers are due not to selective action, but rather to the fact that the radium-skin distance is short, and that most of the energy is absorbed in the tumor proper. He summarizes the advantages of low-voltage, short-distance x-ray therapy as follows:

1. There is no difference between the clinical effects of the same dose of x-radiations of different wave lengths; the important factors being the energy absorbed per cubic centimeter, and the time spacing of the irradiations.
2. The healthy surrounding tissues should be spared irradiation as much as possible, in order to aid subsequent repair.
3. The distribution of radiation in the tissues with small focal distances is similar to that obtained with radium surface applicators.
4. High-dosage rates of the x-ray apparatus make it possible to treat many patients.
5. The method is cheaper than using radium.

DESCRIPTION OF CHAUL LOW-VOLTAGE ROENTGEN APPARATUS

Chaul suggested the details for the manufacture of an apparatus for low-voltage ther-

apy. This particular apparatus is essentially limited to a voltage range of 50-60 kilovolts. The target-skin distance usually varies from zero to five centimeters. It is therefore particularly adapted to the treatment of more accessible or more superficial tumors than the Schaefer-Witte apparatus. Chaoul recommends contact or short-distance low-voltage x-ray therapy for (1) skin cancers; (2) buccal cancers including lip, cheek, tongue, alveolus, tonsil and pharynx; (3) recurrent skin nodules of mammary carcinoma; (4) cancers of the cervix, using the Schaefer-Witte tube; (5) any deep-seated cancer made accessible by the surgeon, e. g., rectal cancer.

THE CHAOL APPARATUS IN PATERSON

The Josephine Lendrim Tumor Clinic of the Paterson, New Jersey, General Hospital has been using a Chaoul apparatus for more than a year. The apparatus consists of a generator, a control box, and a tube stand. It is equipped with an auto-transformer control for keeping the operating voltage constant. The current supplied by the generator is four to six milliamperes, at 60 kilovolts constant potential.

In the Lendrim tumor clinic, the low-voltage contact therapy outfit is equipped with a single-column tube stand. The apparatus is also made with an additional double-column stand. The single-column tube stand is used for superficial cancers, while the double-column stand is used for treating tumors situated in various cavities of the body. In using the double-column tube stand, the applicator is centered upon the tumor and fixed in this position before the x-ray tube proper is applied. If the outfit has both a single-column tube stand and a double-column tube stand, it must be equipped also with a high-tension change-over switch immersed in oil for alternative operation of two x-ray tubes. While treatment is being given to one patient on one tube stand, the other x-ray tube can be adjusted to a second patient. This is time-saving. For small clinics the double-column tube stand may be dispensed with for economic reasons. Where time is no object, satisfactory placement of the tube in body cavities can be accomplished with a single-column tube.

The tube shield housing the low-voltage tube is shown with the cathode at one end, and the

target or anode at the end of the long tube. Surrounding the entire length and circumference of the tube, there is a water jacket which is closed at the distal end by means of a very thin metal disc of negligible filter value. This constant flow of cold water around the tube and anode keeps the anode from overheating. The anode is the target for the cathode rays, which energy is transformed on passage through the anode into x-rays. The anode also acts as a filter equal to about 0.2 mms. of copper.

PHYSICAL FACTORS IN CHAOL ROENTGEN THERAPY

As with high-voltage therapy, the time factor is of great importance. For this reason, fractionated doses of 300 to 500 r units are usually applied daily. The total dose depends on the location and size of the cancer. The depth dose curve and the roentgen output per minute depend on the target-skin distance. The value of the total dose depends upon the size of the fields and the intensity of the individual doses. The important and significant factor, however, is the desired effect.

The anode, which measures two and a half cms. in diameter, may be placed in direct contact with the cancer. Cones or applicators whose inner diameter measures two and a half cms. can be placed over the anode-bearing tube. By the use of these cones the target-skin distance may be altered from zero to three cms. or five cms.

The apparatus used by the authors delivers on contact application 800 roentgens per minute; with a cone giving three cm. distance, 88 roentgens per minute; and with a five cm. target-skin distance, 36 roentgens per minute. These values have been obtained through calibration with an ionization chamber. The cones used at target-skin distances of three and five cm. are of varying sizes and shapes to fit the particular cancers to be treated. Cones with a terminal aperture greater than the diameter of the target taper down to the target size. When a superficial effect is desired, cones are not used and a contact application is made. The metal disc at the end of the tube is placed directly against the tumor. The cones designed to give target-skin distances of three or five centime-

ters are used when the cancer is deeper or thicker, and greater penetration of the x-ray beam is desired.

The biologic response of tissues to this type of radiation has not been thoroughly studied. The determination of the skin erythema dose with the particular factors furnished by this method, is a problem now being investigated by the authors.

The cancer receiving the fractionated doses is kept under constant observation to note the amount of regression. Treatment must be individualized in order successfully to treat carcinomas. The reactions of the skin and the mucous membranes resulting from exposure to contact low-voltage x-ray therapy are similar to those due to high voltage x-ray therapy. As soon as epidermolysis is observed, treatment is usually discontinued. The skin reaction is the biological indicator, and the r unit is the physical indicator.

TREATMENT OF EPITHELIOMAS OF THE SKIN

During the past year, at the Josephine Lendrum Tumor Clinic, more than fifty patients with various types of malignant tumors were treated by this method with highly satisfactory results.

This modality is especially adapted for the treatment of *skin carcinomas*. A cone large enough to cover an area about one-quarter inch larger in diameter than the diameter of the cancer is chosen. If there is considerable induration at the base of the lesion, a five-centimeter distance is chosen. If the cancer is very superficial, a contact application is made.

The fractional principle is employed. Three hundred to 400 r units are given daily. The total dosage ranges from 6000 to 9000 r units, depending on the thickness, and the size of the cancer, and the rate of regression. The results have been very gratifying. Although these patients with epitheliomas of the skin have been followed only one and a half years or less, we are satisfied with the cosmetic appearance of the irradiated skin, and we have not observed any local or regional recurrences.

The use of this method on skin carcinomas is particularly valuable in treating epitheliomas around the eye. This method precludes the use of protective moulages so necessary when ra-

dium is used as the curative agent. The use of the Chaoul cones prevents a divergence of the x-rays and the penetrating effects of the rays are so slight that only slight damage to the surrounding tissues ensues. The advantage of this method over radium comes from sharp localization of the beam, and the steep gradient of radiant energy. The reaction is sharply circumscribed around the cancer. With this type of epithelioma we have used daily fractions of 250 to 400 r units, with total dosages ranging anywhere from 3000 to 8000 r units, depending on the dimensions and radiosensitivity of the cancer. Our immediate results have been satisfactory. Edema and inflammation of the conjunctiva have been reduced to a minimum.

Such low-voltage roentgen therapy has had particular value in recurrent carcinoma of the skin. It has been used with excellent results in certain instances where the cancer had already received intensive irradiation. The use of any other modality for these recurrent or residual cancers would have resulted in irreparable damage to the surrounding normal tissues and serious radio-necrosis. This method is definitely indicated for the treatment of recurrent carcinoma in areas already heavily irradiated. We have also used it to treat recurrent skin nodules from carcinoma of the breast. These nodules may be treated by means of direct contact or with a cone giving a target-skin distance of three or five cms. depending on the thickness of the nodule.

TREATMENT OF EPIDERMAL CARCINOMA OF LIP

In treating epidermal carcinoma of the lip, it is possible to apply the cone externally and internally, and thus obtain a cross-firing effect on the cancer. Fractionated daily doses of 300 to 400 r units have been used for total doses of 4000 to 6000 r units to each of the portals. Chaoul reports that over a period of three and a half years he treated twenty patients with labial carcinoma by this method. He obtained up to the present time 90 per cent absolute cures. The results obtained by the authors have been equally satisfactory. Of course, we cannot draw a comparison between these results and the results obtained from the radium treatment of cancers of the lip, because the time of observation of those patients treated

by the Chaoul technic is still too short. The immediate cosmetic results following low-voltage x-ray therapy is comparable to the result following radium therapy.

TREATMENT OF INTRA-ORAL CANCER

The use of this method for intra-oral cancer has several added advantages over radium. The



FIGURE ONE A
Intra-oral roentgen therapy of carcinoma of buccal mucosa.

interstitial use of radium or radon means puncture wounds in the intact mucosa, and this often means introduction of infection. Furthermore, interstitial radium therapy, in spite of great care in the placement of the containers,



FIGURE ONE B
Epidermoid carcinoma of buccal mucosa (cheek) prior to roentgen therapy.

and in determining the dosage, often causes radio-necrosis of the mandible or superior maxilla. The application of the Chaoul tube is convenient, quick, and time-saving.

In the treatment of many intra-oral cancers, the low-voltage technic is used as a supplement to high-voltage x-ray therapy. Very often these cancers are so situated that it is possible to cross-fire at the intra-oral cancer with a high-voltage x-ray beam through an external portal, and with a low-voltage x-ray beam through an internal portal. This permits the delivery of great amounts of radiant energy to the tumor mass. The factors of this external beam are usually 200 kilovolts, target-skin distance 60 centimeters, filtration of one millimeter aluminum, and one-half millimeter copper. The total



FIGURE ONE C
Same patient. Five months later following intra-oral contact roentgen therapy.

dosage usually ranges from 3000 to 5000 r units, and it is usually given in fractions of 300 r units daily. The factors of the intra-oral beam are 60 kilovolts, target-skin distance three or five centimeters, and filtration of 0.2 millimeters copper. The total dose of this type of radiation ranges from 3000 to 6000 r units, and is given in daily fractions of 250 to 300 r units.

The authors have treated several epidermoid carcinomas of the tongue by means of a combination of external high-voltage x-rays and intra-oral low-voltage therapy. The results were very gratifying. There is no reason why interstitial radium or radon could not also be

used in conjunction with both former modalities where such an indication arises.

If the cancer is situated in an accessible portion of the pharynx, one can anesthetize the area with cocaine, and then treat it with fractionated doses of low-voltage contact or short-distance x-rays. Here also one may be compelled to treat the cancer by a combination of modalities; i. e., high-voltage x-rays through an external portal, and low-voltage x-rays through an intra-oral portal. Furthermore, any residual cancer could be treated by interstitial irradiation.

TREATMENT OF CARCINOMA OF THE RECTUM

Chaul extended the application of this method of treatment from accessible tumors to tumors made accessible by surgical procedures. For experimental purposes he concentrated on carcinoma of the rectum, because surgical methods permit access to the rectum, and because it had been demonstrated that excellent results in the treatment of rectal carcinoma were obtained with interstitial implantation of radium or radon.



FIGURE TWO

Intra-cavitary roentgen therapy of carcinoma of rectum.

Chaul made use of a special surgical technic, planned by Krauss, known as a *posterior superior proctotomy*. A preliminary double-barrelled colostomy is performed. A fortnight later, the exposure of the rectum is made. A sacral incision avoiding injury to the sphincter, and with removal of the coccyx and part of the os sacrum, is thus carried out. The posterior wall of the rectum is laid open by a longitudinal incision. The entire lesion is thus exposed and made accessible to the applicator of the low-voltage apparatus. The treatments

are begun five to ten days later. Daily doses of 400 to 500 r units are applied per field; and this is continued until the tumor disappears; 10,000 to 15,000 r units per field are usually required before satisfactory regression takes place. After observing the patient for two to three months, and no evidence of tumor can be found, restitution of the normal rectal passage may be carried out. This is done by excising the cicatrix and draining the oral part of the intestine through the sphincter. Chaul reports excellent results with several patients thus treated.

Malignant tumors situated very low in the rectal canal, or in the anal canal, may be treated by applying a suitable cone directly against the cancer. The authors have treated several inoperable rectal cancers by this technic and the method gives promise of satisfactory results.

TREATMENT OF CANCER OF VAGINA AND CERVIX UTERI

The small size of the Chaul cones not only enables insertion into the anal canal, but they may also be used to insert into the vagina for the treatment of cancers of the vagina or cervix uteri.

Schaefer and Witte, of Gottingen, Germany, have been enthusiastic concerning the use of the short distance, low-voltage method of irradiating gynecological cancers. The advantages of using such a method can be summarized as follows:

1. The skin is completely protected, since the tumor is hit directly by the beams.
2. In consequence of the nearness of the focus, and the filter, the neighboring normal tissues are protected.
3. It is possible to give doses in fractions to the parametrium, never before possible.
4. It is possible to treat residual cancer or recurrences with large doses in patients whose skin cannot tolerate any further external radiation.

In the treatment of *cervical carcinomas*, Schaefer and Witte use a combination consisting of intrauterine radium 3000 to 4000 mghrs. followed by high-voltage external irradiation. The patient is then treated intravaginally by means of the low-voltage apparatus; 2000 to

2500 r units are delivered to each parametrium as a minimum dose. The target-skin distance commonly used is five centimeters. This technic is particularly valuable for cervical cancers in the stage III League of Nations classification. In these cancers, recurrence in the para-



FIGURE THREE

Intravaginal roentgen therapy of cervix uteri. This treatment is used to supplement the intrauterine tandem of radium capsules and the high-voltage roentgen pelvic cycle.

metrium is common, which in spite of further irradiation, usually does not respond to treatment. The use of internal radiation, however, may enable the therapist to treat these parametrial infiltrations with large local doses without seriously harming the adjacent healthy tissues.

MARSUPIALIZATION AND INTRA-CAVITARY ROENTGEN THERAPY OF CANCERS OF URINARY BLADDER

The principle of surgical accessibility has been applied by the authors to the treatment of bladder carcinomas with low-voltage x-ray therapy. Treatment of bladder cancer by external high-voltage x-rays or cystotomy with fulguration and implantation of radon seeds, has not been completely satisfactory. This new technic consists of marsupializing the bladder with the abdominal wall, so that the cancer remains accessible for an extended time. About five or six days are allowed to elapse to assure anchorage of the bladder wall to the abdominal wall. The opening in the bladder is kept patent by a large-sized Marion drain. One hour before each treatment, the patient is given a small dose of *avertin rectally*. The sterile-gloved fingers may now be inserted into the bladder, the drain removed, and the cancer palpated. Under direct vision a suitable roentgen cone can be applied directly to the cancer.

The optimal fractional doses have not yet been found. We have used 2500 r units every other day for a total dosage of 25,000 r units. When satisfactory regression has taken place, the treatments are discontinued, and the cyst-



FIGURE FOUR

Marsupialization and intra-cavitary roentgen therapy of cancer of urinary bladder.

totomy wound is closed. Although the experience of the authors with this new method is limited, still we cannot help but think that this principle of marsupialization of the bladder with administration of fractionated doses of low-voltage x-rays directed to the cancer holds promise for greater success than any other present-day technic.

SUMMARY

The authors have used the low-voltage Chaoul apparatus on malignant neoplasms wherever this method of therapy has been indicated. The indications have been *radio-sensitivity* and *accessibility* of the cancer. The use of this method has been extended to include tumors made accessible by surgical procedures. The principles involved in the use of this technic have been outlined. The authors believe that this method is a valuable addition to the armamentarium in the treatment of cancer.

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REPORT OF A CASE OF BILATERAL CAVERNOUS SINUS THROMBOSIS, RECOVERY WITHOUT OPERATIVE INTERVENTION

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Read before the Eye, Ear, Nose, and Throat Section of the Annual Meeting of The Medical Society of New Jersey, in Atlantic City, on May 19, 1938.

During the last year there was admitted to the service of Dr. James S. Shipman at the Cooper Hospital a case of bilateral exophthalmos. A diagnosis was made of cavernous sinus thrombosis. Because of the bilateral nature of the condition, operative procedure was decided against, and conservative treatment was instituted, with the expectation that the patient would come to an early death. Much to our surprise, the patient recovered after a most stormy convalescence. Since our initial diagnosis was cavernous sinus thrombosis, and we have not been able to find a better one, we have also made it our final one, and offer it to you for your consideration.

ANATOMY

Most of us are familiar with the anatomical-physiological aspect of the cavernous sinus, but I will briefly review some of the salient features. The sinuses are two in number, one on each side of the body of the sphenoid bone. They are large, irregular venous sinuses, broken up by numerous trabeculae, extending from the sphenoidal fissure in front to the apex of the petrous portion of the temporal bone behind. They are intimately connected across the median line by the circular sinus around the pituitary body, and by a plexus of veins across the basilar process.¹ When the circulation is normal the sinus receives blood from the sphenoparietal sinus, the inferior and anterior cerebral and middle meningeal veins, small veins from the sphenoidal air sinuses, and from the upper part of the forehead and orbital region through the ophthalmic vein.

The branches that lead away are the small veins through the foramen ovale, the Canal of Vésalius, the foramen lacerum medium and the foramen rotundum, to communicate with the pterygoid plexus deep in the pterygoid fossa. There are also many fine veins which

come from the cavernous sinuses and surrounding the carotid artery pass downward to reach the jugular bulb. In addition to these the superior and inferior petrosal sinuses drain from the cavernous sinuses.

The flow may vary because of changes in such conditions as gravity, muscular exertion, relative pressure within and without the cranium, and the respiratory cycle.² The anatomy of the sinuses has a tendency to slow the blood so that too rapid circulation will not take place, and this in itself makes this site a logical spot for a thrombosis.

The local sequelae of thrombus formation are organization of the thrombus and enzymic softening. The latter is caused by the action of the proteolytic enzymes set free during the degeneration of the leucocytes; and it leads to canalization of the clot and restoration of the normal flow in the affected vein. As the flow is restored recession occurs in the granulation tissue.³

The literature is sparsely scattered with cases of recovery. Eagleton reports numerous cases cured by operative intervention,⁴—a recovery of 19 per cent in thirty-two cases.⁵ Cavanaugh reports twelve cured cases, seven of which could be called the acute infective type, and only a few of these cases recovered spontaneously.⁶

E. R. Lewis reported a most interesting case with recovery, the diagnosis being verified by necropsy.⁷ The case presented the clinical picture of thrombosis, staphylococcus aureus bacteremia, toxic encephalitis, and extensive acute cranial and spinal meningitis. The patient died three years later from an acute tympanomastoiditis, and autopsy confirmed the previous diagnosis.

In most of the cases reported the blood cultures have been positive for *staphylococcus aureus*. In four cases during the last four

years at the Cooper Hospital, three had positive cultures for staphylococcus aureus, no blood culture having been taken in the other one. All patients died except the one being reported.

The patient, a young girl aged seven, was admitted on the evening of September 20th, with a diagnosis of bilateral cavernous thrombosis. The history contained the fact that the child had a sty on the outer part of the lower left lid three days previously, which she had squeezed with her fingers. The child at this time was markedly toxic, with a temperature of 104°. External examination of the left eye showed the lids greatly swollen, with marked chemosis of the bulbar conjunctiva. There was marked proptosis of the globe which was fixed. There was evidence of some purulent infection at the outer third of the left lower lid. The pupil was not dilated but reacted fairly well to light. Examination of the right eye showed the same findings, except there was no evidence of external infection, and proptosis was not quite as marked.

Ophthalmoscopic examination of the right eye revealed a slight overfilling of the veins, with blurring of the disc margins. Due to the steamy cornea in the left eye, the fundus could not be seen clearly.

A diagnosis was made of bilateral cavernous sinus thrombosis resulting from an infected hordeolum.

Immediate treatment, consisting of hot boric acid compresses, mercurochrome, and mercuriophen wash, was instituted. Ten c.c. of prontosil were given every four hours for six doses. Sulfanilamide, grs. x, was given four times a day for four days. Liquid petrolatum was used every two hours to try to offset any tendency to exposure keratitis.

The fever stayed elevated for about eighteen days. The blood count showed a marked neutrophilic leucocytosis which increased from 18,850 to 24,600 on the tenth day. On the twentieth day the fever had receded to normal. The red blood cells showed an increasing diminution and an attempt was made to get a donor for transfusion; but a suitable one could not be found. On discharge her blood count had returned to practically normal. The eye culture and blood culture taken on the first day of the disease showed pure cultures of staphylococcus aureus. On the fifteenth day of the disease the blood culture was negative. X-ray examination was negative for sinus or bone involvement.

During the first four weeks the patient was irrational. The neurologist felt that she had a cavernous sinus thrombosis and meningeal irritation; but because of the toxic condition of the patient he did not think it advisable to do a spinal puncture. The eyelids remained swollen and on the fourth day there appeared an area of tenderness and fluctuation over the superior nasal portion of the left upper lid, which seemed to point under the skin. This was incised and a large

amount of pus expressed. On the fifteenth day the patient's temperature again increased and on the seventeenth day the right lid was incised with the evacuation of considerable pus, and the patient continued to improve.

During this time no ophthalmoscopic examination could be done, except that of the first day, because of the steamy condition of the cornea and because of keratitis. On about the fortieth day the fundus of the right eye could be seen and it appeared to be normal except for slight overfilling of the veins. The left fundus was seen a few days before the patient was discharged and appeared to be normal.

In spite of the constant care received, the patient developed an ulcer of the lower part of the left cornea on the thirteenth day, and this continued to enlarge and grow deeper until it perforated. After perforation the ulcer filled in with iris and healed very quickly.

The right eye condition was complicated by a superficial ulceration that started in the lower part of the cornea and healed without perforation.

In about the fourth week of treatment the patient showed definite signs of improving, although she was very weak. From this time on she continued to improve; and on the fifty-fifth day after admission she was discharged to the clinic with a vision of 6/30 in the right eye and 6/60 in the left eye, without correction.

At the present time her eyes are completely cleared up except for an anterior synechia, with leucoma in the lower third of the left cornea and a small scar in the lower third of the right cornea. Her vision is 6/6 in the right eye and 6/12 in the left eye, without correction.

I have reported to you a case of bilateral exophthalmos that we have diagnosed as cavernous sinus thrombosis. The other possible diagnosis is bilateral orbital cellulitis with septicemia. We did not think it was cellulitis because this is very rarely bilateral and because of the marked cerebral symptoms in the patient. The abscesses of the lids were considered a secondary infection.

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DISCUSSION

BY OSCAR V. BATSON, M.D., PHILADELPHIA, PA.

(By invitation)

The outcome of Dr. Barnshaw's case represents more than the successful termination of a clinical experience. The lesion in cavernous sinus thrombosis is anatomically so deeply situated, and the surgical approach is so intricate and so unsatisfactory, that every recovery through chemo-therapeutic measures is a distinct advance.

I had the opportunity, during the progress of this case, to see photographs of the patient, and to inspect the temperature chart. At first I discussed with Dr. Barnshaw the possible approaches for operation; and a little later, I must confess, even discussed the removal of pathological specimens.

The anatomical relations may be briefly summarized as follows: About the upper lip, the nose, and the orbit, the venous blood may travel to the neck either superficially through the anterior facial vein, or it may enter the neck by proceeding to the orbit through the angular vein, then through the superior ophthalmic vein, through the cavernous sinus, and finally to the jugular bulbs. Since here there are no valves, the flow in the veins is determined by the propulsion from the capillary side, by changes in posture, and by impediments to flow, such as those produced by the pressure of an edema. Therefore, an edema may cause the course of an infected blood stream to be through the cavernous sinus, with the subsequent involvement of the meninges. Any phlebitis would give severe systemic reactions; but here the severity of the systemic diseases is masked by the onset of the meningeal symptoms.

When the infection is in the lower part of the face, edema may prevent the course of blood

through the superficial channels, but an alternate deeper pathway can carry the stream. This pathway is through the pterygoid plexus of veins, and it lies outside of the cranial cavity. To my mind, this anatomical difference in the relationships of the alternate pathways, the one through the meninges and the other outside of the skull, determines the severity of the infections in the upper and the lower facial areas.

Dr. Barnshaw has mentioned that most of these cases are produced by the staphylococcus. It can be safely said, I believe, that in the fatal cases of less than one week's duration, the infecting organism has been the streptococcus. The course of the staphylococcus infection is much slower.

The multiple channels in the venous system preclude the possibility of a single ligation arresting the progress of a diseased blood stream flow. In my experimental (post-mortem) injections it has been impossible to prevent the filling of the cavernous sinus even after extensive ligations on the face have been performed. This would make it seem that any virtue that the ligation is supposed to possess may come from the incision which acts as an avenue for drainage.

I know that there is a tendency among clinicians to say that there has been an error in the diagnosis when a cured case of cavernous sinus thrombosis is reported. In examining clinical records, the only difference between Dr. Barnshaw's case and those records of proved cavernous sinus thrombosis is the absence of an autopsy report. This case goes into the column of statistics already slightly in favor of the medical treatment of cavernous sinus thrombosis.

REPORT OF A CASE PRESENTING MULTIPLE AREAS OF ENTERITIS

By GEORGE BLACKBURNE, M.D., Newark, N. J.

So much has been written on the subject of regional ileitis and enteritis since Crohn defined it as a definite condition in 1932, that I would like to add to the literature the following case, in which there was involvement of three distinct areas during a period of five weeks. Jackson has already reported a case with multiple loop involvement.

Mrs. C. R., housewife, nullipara, aged twenty-eight, was seen by me in consultation with Dr. W. A. Nemzek on June 9th, 1937. Patient was a frail young woman, with a history of having been operated upon for acute appendicitis eighteen months ago, followed by a stormy convalescence. Lower

abdominal symptoms had persisted after operation, and gastro-intestinal x-ray studies had been made, but with negative results.

The present history was that on June 7, 1937, she was seized with severe lower abdominal pain, at first dull, but later becoming cramplike. The bowels were moved with the aid of enemas, but there had been no passage in the past twenty-four hours. Vomiting had occurred several times, but seemed to consist only of gastric contents.

Physical examination showed moderate rigidity of the abdomen, with slight distention, and pain on palpitation below and to the right of the umbilicus. Pelvic examination showed tenderness in the right fornix, but no masses were felt. Temperature 99, pulse 80, respiration 20. The urine was essentially negative.

A diagnosis of partial intestinal obstruction was made, and as the symptoms became more acute, operation was decided upon and performed at St. Michael's Hospital, on the evening of June 9th, 1937, under gas-ether anesthesia, after a preliminary intravenous injection of 1000 c.c. of five per cent glucose in saline.

Two dense bands of adhesions were found involving the lower ileum and producing a partial obstruction. These were severed. About eight inches of gut in the region of these bands was a deep purple color, markedly hemorrhagic, thickened, and oedematous, but glistening. The mesentery was thickened. As the color of the bowel seemed to improve after cutting the bands, a diagnosis of *adhesions with regional ileitis* was made, and the abdomen was closed.

Convalescence was rather rocky, with vomiting, hiccough, persistent low-grade temperature, and some distention. These symptoms became very acute, and on June 19th, 1937, after consultation with several staff members, it was decided that we were faced with another surgical emergency, and another operation should be performed. During the preceding ten days, the Levine tube and intravenous had been used occasionally, and the bowels had moved with petressin and prostigmine. On June 19th, 1937, after a blood transfusion of 500 c.c., the abdomen was reopened through the previous abdominal incision, and the section of bowel which had previously been hemorrhagic, was found to be shrunken down to about one-third the diameter of normal bowel, was clay-colored and lifeless looking, and was matted up with adhesions. About six inches of bowel proximal to this area was hemorrhagic and oedematous, with thickened mesentery, giving the same appearance that the other piece had at the operation ten days previously. This was quite evidently an additional acute area of involvement, the former area having resolved into the thin, grey, lifeless-looking tube mentioned above.

About fourteen inches of intestine were resected, including the old and the recently involved area; the ends were closed, and a side anastomosis performed. An ileostomy was done and a small catheter inserted above the anastomosis. Rubber tissue drains were placed in the region of the anastomosis, and the abdomen was closed.

Convalescence was again stormy, and the Levine tube and intravenous were frequently used for vomiting and distention. The temperature ranged from 99 to 103; pulse 84 to 130. There was a slight fascial infection about the drains and ileostomy tube, which was permitted to be open part of the time.

On June 28, 1937, a parotitis developed on the left

side, and a radium pack was applied by Dr. Edgar A. Ill. Fluctuation over the gland became evident on July 3rd, 1937, and an incision was made, and another blood transfusion performed. There was free drainage from the gland and the patient seemed to be doing fairly satisfactory for several days. During this period the drains and ileostomy tube were removed, and the bowels were moving with formed feces.

On July 9th, 1937, the patient complained of severe pain in the left upper abdomen and splenic region, and the temperature and pulse rose. Another blood transfusion was given, but she died rather suddenly on July 10th, 1937, with signs of shock and toxemia.

AUTOPSY

Autopsy showed an additional area of acute enteritis involving two feet of the upper jejunum. This bowel was blue, congested, oedematous, and hemorrhagic, and the mesentery was thickened,—the same conditions that the previous loops had shown. The anastomosis in the lower ileum was functioning satisfactorily.

The pathological report on the resected area from the second operation was made by Dr. John W. Gray. It showed two different areas of pathology. The distal end showed the mucosa intact, with subserous fibrous thickening, and lymphocytic infiltration. The proximal end showed marked congestion and oedema, particularly in the outer layers, with polynuclear as well as lymphocytic infiltration. The pathological report on the involved area of jejunum, found at autopsy, was very similar to that of the proximal end of the resected portion.

This is one of three cases that I have encountered in the past year. This one was unusual in that more than one area was involved, and at different times. I would like to second the suggestion, previously advanced, and recently emphasized by Meyer, that when these cases are met with, and the bowel seems viable, a short circuit operation be done between healthy bowel above and below the lesion, leaving the involved area in situ for the time being, and instituting a watchful waiting policy. Regional enteritis should be suspected and looked for in appendix operations where insufficient pathology is found; and in acute and chronic cases with vague abdominal symptoms or partial obstruction.

HEALTH MAINTENANCE IN INDUSTRY

By C. D. SELBY, M.D., Detroit, Michigan

Abstract of a paper read before the Annual Meeting of the American Public Health Association,
October 25, 1938.

The workman in industry is employed about one-quarter of his time. It is only in this respect and to that extent that his life differs from that which is common to his community, and the position he occupies in it. The causes of sickness and injury may originate at any time during the 24-hour cycle of each day. Some are definitely occupational, some are definitely non-occupational, and in some, the origin may be doubtful.

The definitely occupational are responsible for about six per cent of the workman's total annual disability from sickness and injury. In other words, 25 per cent of his time, or his occupation, accounts for only six per cent of his annual disablement. This clearly places the major problem of maintaining employee health in the employee himself and his community rather than in the plant; and it immediately brings up the question—What can the plant physician do about it?

He can do this. He already has a well-organized health maintenance program which experience is proving to be effective insofar as the occupational disablements are concerned. He can extend this program to include studies of non-occupational sickness. He can act as a case-finding agency for the local private physicians who care for the workman; and he can act as an aid to the local health officer.

In connection with the handling of the occupational disabilities, the plant doctor is occasionally faced with the necessity of passing upon the validity of claims for compensation. His decisions, whether large or small amounts are involved, are always important because of their possible influence upon employee relations. He must not, however, be influenced by this fact or by the fact that he is employed by the management. A partisan plant doctor cannot for long hold the confidence of either management or the employee group.

The treatment of occupational disabilities is still a major function of industrial medicine and in many places it is the dominant function.

If partisanship is pursued to the point where the doctor becomes known for his bias, he is seldom competent to protect either his company or the health of the workmen. An effective health maintenance program in particular is built up on confidence. The plant physician is always on sound ground when he gives his employee patients the consideration he would if they were private patients; and in this, all they ask is that he be fair.

SAFE PLACEMENT

Having become familiar with working environments and conditions, the doctor is able to advise in the safe placement of new workmen. In order that new workmen may be assigned to occupations for which they are suited and can safely perform, a knowledge of their physical conditions is necessary. To obtain this knowledge is the purpose of the preemployment examination. Certainly it must be sufficiently thorough to enable the doctor to advise intelligently as to placement. As this is only the beginning of the workman's plant life, the examination must also serve as a source of information to guide the doctor in his subsequent efforts in behalf of the workman's health and his continuing safe employment.

Periodical examinations are to secure early diagnosis of preventable diseases and adjustments in occupation if necessary. They are essential to the control of occupational diseases. They should be as complete as the doctor requires for a conclusion, and they should be made often enough to give the workman health protection, but not less frequently than annually.

Reëntrance examinations should be made after absence from illness or injury. They are to protect workmen against a too early return to usual work, or to effect changes in occupation if indicated. These need not be more extensive than in the judgment of the physician is required to safeguard the workman and the employer.

HEALTH INSTRUCTION

The best of health instruction is that which follows physical examinations, or accompanies consultations. This is personalized instruction, and as such is very effective. Every visit of every employee to the medical department, and these frequently equal 100 per cent of the total number of the employees monthly, makes an opportunity for health instruction.

RECORDS

These should show the results of all physical examinations and consultations and will include particularly detailed reports on injuries and illness, descriptions of physical findings, treatments, estimated periods of disability, end results, and all other information pertinent to cases or required by statute for Workmen's Compensation claims or other purposes. In short, records should be sufficiently complete to permit the making of statistical studies.

CASE FINDING

Needless to say, employees found to be suffering with correctable conditions are referred to their family physicians. This phase of industrial medicine serves as an important agency for the general profession and the public health authorities. This is particularly true with reference to tuberculosis, syphilis, the cardiorenal diseases, vascular diseases, and many others which need not be mentioned.

STUDIES OF SICKNESS

The plant physician has a splendid opportunity to accumulate data relative to the in-

stance of non-occupational sickness and injuries as well as the occupational. Although not a responsibility of industry, their prevention and control is preëminently desirable. As a means toward this end, the plant physician collects and analyzes statistics concerning sickness relating to occupation, sex, age, and other facts that may involve, or be involved, in the health of the workmen.

CO-OPERATION WITH THE MEDICAL PROFESSION

The plant physician is dependent, to a large degree, upon the local medical profession; and the local profession is, in reality, an element in the plant medical service. It is desirable, therefore, that the industrial physician make it clear to the local profession that, although he is in a sense an uninvited consultant, he is at the same time a very valuable ally.

CO-OPERATION WITH OFFICIAL AND NON-OFFICIAL AGENCIES

Industrial medicine is coming to realize more than ever before its opportunities for service in the public health field. It is the only organized point for attack against the preventable diseases in the employed group, which is, in reality, a *definite age group*. Industrial medicine may serve in the public health field for this group in a manner much as has already been done in relation to infants, children, and adolescents. This opportunity becomes increasingly evident as the control programs for tuberculosis and syphilis develop.

3044 W. Grand Boulevard

A LESSON FROM A DEATH CERTIFICATE NUMBER FIVE

By A. W. BINGHAM, M.D., East Orange, N. J.

Primipara. Normal delivery. No vaginal examinations. Short labor.

Patient had no foci of infection. Chill on third day, followed by rise of temperature every day. Died on seventeenth day of puerperal septicemia.

How did she become infected? Was there any break in sterile technic? Did any attend-

ant have a cold or sore throat? Did the physician and nurses all wear masks? Masks should be worn while examining or treating patients as well as in the nursery. Both physicians and nurses should wear them routinely in the home delivery as well as in the hospital so as to add this protection in every case.

Prevention is so important.

Treatment so often fails.

HEMORRHAGE DURING PREGNANCY, WITH SPECIAL REFERENCE TO THAT DURING THE LAST TRIMESTER

MATERNAL WELFARE ARTICLE NUMBER THIRTY-THREE

By HARVEY B. MATTHEWS, M.D., Brooklyn, N. Y.

Clinical Professor of Obstetrics and Gynecology, Long Island College of Medicine; Attending
Obstetrician and Gynecologist, Methodist-Episcopal and Long Island
College Hospitals of Brooklyn.

Read before the Section on Obstetrics and Gynecology of The Medical Society of New Jersey on May 18,
1938, at Atlantic City, N. J.

Hemorrhage from any source is alarming; hemorrhage during pregnancy is always frightening. If this statement is true, then it must be admitted that one of the first steps in the management of hemorrhage during pregnancy is a deliberate, informed, and well-balanced doctor who can make a diagnosis and proceed to carry out the proper treatment. Many a patient has lost her baby—perhaps her own life—from hemorrhage during pregnancy because her doctor did not realize the seriousness of the situation. On the other hand, it occasionally happens that the patient herself must be blamed for the calamity because, although told what to do by her physician, she failed to obey instructions.

What is the answer to this important question? It is:

1. Better obstetric training for the doctor.
2. More adequate prenatal care for the patient.

By a good physical examination on the first visit to the pregnant woman, coupled with regular periodic observation and laboratory "check-up"—proper prenatal care—we can best detect the primary cause of hemorrhage, as well as other pathological lesions, during the pregnant state.

The physician who does not supervise his obstetric patients in this manner can expect difficulties in a certain percentage of his cases. Negligence in such matters is less forgivable than ignorance. It is usually not ignorance, for as a teacher I can assure you that every medical student, at least in the Long Island College of Medicine, has had ample instruction in prenatal care. The Children's Bureau of the United States Department of Labor, the American Maternal Health Committee, and many State agencies throughout our country are sup-

plying much first-class information on this subject.

Furthermore, your own New Jersey State Medical Society is doing yeoman service in disseminating dependable information on all phases of Maternal Welfare for which the mothers and mothers-to-be of your State may well be proud. The campaign must continue if we are to lower our maternal mortality commensurate with our standing amongst the leading nations of the world.

The *early* hemorrhages of pregnancy are chiefly caused by abortion—threatened or inevitable,—and to a lesser extent by ectopic gestation. Massive erosions of the cervix and cancer of the cervix are causes sometimes encountered. However, since time nor space does not permit a detailed discussion of these early hemorrhages, we shall pass on to the main theme of this discussion, viz.: hemorrhage during the last trimester of pregnancy.

Placenta previa and *ablatio placentae* are most commonly encountered. *Rupture of the uterus* prior to labor, although a rare but very serious accident, must be kept in mind, especially where previous uterine operations have been performed. Control of hemorrhage, treatment of the shock and delivery of the baby are of prime importance. Secondarily, treatment of the anemia is important. Blood transfusion offers the very best method of combating the shock following hemorrhage; and also for the inevitable anemia that follows in the wake of any considerable loss of blood.

PLACENTA PREVIA

There are three well-recognized types of placenta previa, viz.: marginal, partial or lateral, and central. It is most important that the clinician be able to differentiate between these types

because the success in management depends upon an accurate diagnosis. The aphorism "Without a correct diagnosis there can be no intelligent treatment" is certainly applicable in placenta previa.

The first step in making a diagnosis is the history. A spontaneous, causeless, painless hemorrhage in the last trimester of pregnancy is almost sure to be placenta previa. A pelvic examination must be made in every case of

is the safer procedure, provided the proper precautions are taken.

It is true that we now have the Ude and Urner cystogram method of diagnosing placenta previa, but unfortunately this is not a dependable method. It is merely confirmatory, and therefore a pelvic examination must be made in addition to the cystogram. So far we are not very enthusiastic about the x-ray diagnosis of placenta previa, but we are open-

PLACENTA PREVIA

1. Sudden and painless onset.
2. Hemorrhage is always apparent.
3. Hemorrhage is apt to be mild at first. Later more severe.
4. No apparent cause; sudden painless hemorrhage.
5. Fetal heart heard.
6. Uterus has normal "feel".
7. Outline of fetus on palpation.
8. Placenta palpable on vaginal examination.

VS.

ABLATIO PLACENTA

1. Sudden onset with severe pain.
2. Hemorrhage is concealed or apparent.
3. Hemorrhage usually severe from beginning.
4. Always some cause, as toxemia, syphilis, short cord, trauma, etc.
5. No fetal heart heard.
6. Uterus is tense and tender on palpation.
7. Inability to outline fetus on palpation.
8. No placenta palpable through vagina.

bleeding. However, if placenta previa is suspected, preparation must be made to combat hemorrhage should the pelvic examination produce an exacerbation of the bleeding. If a hospital is accessible, the patient had best be given a stiff dose of morphine ($\frac{1}{4}$ to $\frac{1}{2}$ gr.), and be moved to the hospital before a pelvic examination is attempted.

Under any circumstances, complete thorough pelvic preparation should be carried out, including shaving of pubis and vulva, a full ten-minute scrubbing of the hands, in addition to the use of sterile rubber gloves, with sterile instruments and vaginal pack (ten to twenty yards of two- or three-inch gauze) ready for use before the examination is begun. We have seen several cases bleed quite profusely during a pelvic examination, and in one instance the patient's life was saved only by quick Cesarean section and blood transfusion. There is a real hazard in pelvic examination in placenta previa, but I believe it should be performed, but only under the conditions outlined above. A diagnosis must be made and we must choose the lesser of the two evils, viz.: "Guessing" what the cause of the bleeding is, or producing more and perhaps severe bleeding by doing a pelvic examination. We think the pelvic examination

is the safer procedure, provided the proper precautions are taken.

In making the diagnosis of placenta previa, besides the history and the apparent bleeding, there are rather definite palpable signs on pelvic examination which, when present, leaves no doubt as to the true condition. They are:

1. The edema and boggy feel of the cervix and lower uterine segments.
2. The presence of "cushiony" mass between the examining finger and the presenting part in a certain area, whereas in other areas there is the normal "feel".
3. The very evident pulsations of the uterine arteries, which occasionally is not particularly significant because there are other pelvic lesions in which these pulsations are present.

In the differential diagnosis between placenta previa and ablatio placenta, remembering the above table should be of inestimable value.

Once the diagnosis of placenta previa is made, the pregnancy should be terminated, except in very special cases of marginal or partial placenta previa, where there has not been "shocking" hemorrhage, and where the fetus is just short of viability. In such cases it is justifiable to practice "watchful waiting", always in a hospital, until a more viable baby

can be delivered. In the marked partial or central types, procrastination is absolutely contraindicated.

In accomplishing the delivery, there are three very important underlying principles to be observed:

1. Conserve blood loss.
2. Produce the least possible trauma.
3. Avoid infection.

A patient may lose a very large amount of blood once, but if she continues to bleed even moderately, she may succumb. Whatever method of delivery is used, trauma should be minimized and asepsis rigidly observed. Work gently but rapidly until you have controlled the bleeding, after which there is no hurry. Prepare the patient properly before you start to operate. Infection must ever be in your mind, but make sure it is not on your hands or instruments.

Before Viability.—How shall we terminate the pregnancy before the period of viability? Before viability our only aim should be to control the hemorrhage and secure dilatation of the cervix. To accomplish this, Braxton-Hicks version, bringing down one leg to serve as a tampon or the vaginal pack, or the hydrostatic bag, or both, should be employed. As soon as the bag has produced sufficient dilatation of the cervix, *internal podalic version* should be done, bringing down one or both feet. This controls the hemorrhage. *Do not extract the breech.* Allow labor to proceed and delivery to occur spontaneously. If there is no bleeding and the child is not viable, there is no need to hurry the delivery. Rapid breech extraction produces lacerations, which add more hemorrhage, shock, and possible infection. *Occasionally* Caesarian section should be performed where there is little or no dilatation and the hemorrhage is profuse.

Viability.—When the child is viable, the problem becomes more difficult. Here we must consider the following factors before we can decide on the method of delivery:

1. The amount of cervical dilatation.
2. The amount of hemorrhage.
3. Whether the patient is multiparous or primiparous.
4. The size and condition of the child.

5. The condition of the mother.
6. The type of previa.
7. Whether potentially or actually infected.

In the *marginal* type of placenta previa, when there is sufficient dilatation of the cervix (three or four cm.), simple rupture of the membranes, allowing the head to descend against the placenta, may control the bleeding, and labor may progress in a normal manner. If this fails, and the hydrostatic bag is not available, a Braxton-Hicks version may be done, pulling down a foot, and plugging the cervical canal with the thigh and buttocks of the child, thus controlling the hemorrhage. We never employ Braxton-Hicks version for this purpose unless in an emergency, because it means almost sure death for the child. The fetal mortality for this procedure is terrific—60 to 80 per cent—and therefore it has no place in modern obstetrics, except as the only means of saving the life of the mother.

Now to go back to the case where simple rupture of the membranes does not work. In such a case we proceed by the insertion of the hydrostatic bag (Voorhees' type) to control the hemorrhage, to stimulate uterine contractions, and to promote cervical dilatation. That is just what is needed on the part of the mother; and by it the child's life is not unduly jeopardized.

After the bag has been expelled and the bleeding is controlled by the descent and pressure of the presenting part, the labor may be allowed to proceed as in the usual case. However, if the bleeding is not controlled upon the expulsion of the hydrostatic bag, podalic version, bringing down both feet, should be performed, followed by breech extraction. Proceed in the latter instance carefully, deliberately, and slowly. Make haste "slowly". Never hurry; you may rupture the cervix or uterus, or kill the child, or both. Remember that, in the presence of placenta previa, the lower uterine segment is very friable, and therefore easily lacerated.

The physician must remain with the patient until after the hydrostatic bag has been pushed through the cervix by the uterine contractions and the case delivered. When the bag comes through the cervix, hemorrhage may recur, and

the patient may succumb in a few minutes. *Stay on the job* until the patient is delivered and the third stage of labor is completed. *Then stay a little longer* just to be sure. It might save a life.

In any type of case where the cervix is long, uneffaced, or nearly closed, or in central placenta (primipara or multipara), none of the above measures are recommended for the control of the hemorrhage, and *Caesarian section* had best be performed. The mortality for both mother and baby is remarkably good in Caesarian section for placenta previa. It is, of course, understood that there is no infection present, and that the physician doing the section is competent. Abdominal section is always preferable. Vaginal Caesarian section should never be done, except occasionally in a desperate case where the child is premature and small, because of the friability of the lower zone of

1. Don't examine any bleeding case through an unprepared vulva.

2. Don't leave a case of placenta previa once the diagnosis is made.

3. Don't try to dilate the cervix manually in these cases;—you cannot, you *tear* it.

4. Don't forget that the hydrostatic bag, or vaginal pack, or both, will stop the bleeding and dilate the cervix, if enough *morphine* and time are given.

5. Don't extract the breech too rapidly after podalic version. In most cases when babies are delivered dead or die soon after delivery following version, this is caused by undue haste and trauma.

6. Don't "muss up the case" and then call for consultation. Call for help early before it is too late for the consultant to help you or the patient.

7. Don't do or ask to have done a Caesarian

DIFFERENTIAL DIAGNOSIS

ABLATIO PLACENTA

1. Sudden onset with severe pain.
2. Hemorrhage is concealed or apparent.
3. Hemorrhage usually severe from beginning.
4. Always some cause, as toxemia, syphilis, short cord, trauma, etc.
5. Fetal heart absent, if small separation present.
6. Uterus is tense and tender on palpation.
7. No placenta palpable on vaginal examination.

the uterus, and therefore the likelihood of rupture of the uterus upon delivery of the child with the consequent additional shock from more hemorrhage, later possible sepsis, and still later embolism. Likewise the child, if at or near term, is very likely to succumb to vaginal delivery by this method.

Truly, these are desperate cases. Oftentimes many sleepless hours are spent in bringing them to a successful termination for the mother, and *only* perhaps for the child. However, if we are successful in saving the mother's life, particularly if already there are children at home, the anguish and disappointment at losing the baby in placenta previa is amply appeased.

Before concluding this subject I would like to suggest the following "Dont's for Placenta Previa":

PLACENTA PREVIA

1. Sudden and painless onset.
2. Hemorrhage is always apparent.
3. Hemorrhage is apt to be mild at first. Later more severe.
4. No apparent cause; sudden painless hemorrhage.
5. Fetal heart heard.
6. Uterus has normal "feel".
7. Placenta palpable on vaginal examination.

section on a case of placenta previa that is potentially or actually infected.

ABLATIO PLACENTA

Ablatio placenta, or *accidental hemorrhage*, is due to the premature separation of a normally situated placenta. This accident usually happens in the latter weeks of pregnancy, or during labor; usually the former. The main causes are: (1) Disease of decidua or placenta; (2) toxemia of pregnancy; (3) syphilis; (4) trauma, and (5) short cord. This accident is a real calamity in many instances.

If the hemorrhage is *concealed*, the diagnosis is more difficult. If the hemorrhage is *evident*, the diagnosis is not so difficult. We are apt to think first of placenta previa, but after taking a careful history and making a good physical examination, the diagnosis is usually fairly

easy. On vaginal examination no placenta can be felt. The uterus is very tense and tender and filled with blood, and there is no contraction and relaxation of the uterus. The fetal heart is not heard. Due to the hard, distended, tender uterus, the outline of the fetus cannot be made out.

The severity of the symptoms naturally varies with the amount of separation of the placenta and consequent hemorrhage. A diagnosis of ablatio placenta should be made if the hemorrhage is large in amount, concealed or apparent; if the symptoms appear rapidly and are very severe (sudden severe pain in the belly of a tearing, lancinating character, followed by symptoms and signs of hemorrhage and shock, and later by distention and tenderness of the uterus).

There is another condition that sometimes requires to be differentiated from ablatio placenta, viz.: *rupture of the uterus*. Here we have no uterine contraction, the uterus is small and pushed to one side by a second tumor, the child; there is no presenting part per vagina, and lastly there is a rent in the uterus that can often be palpated. (Refer to section on ruptured uterus.)

The fetal mortality for severe ablatio placenta is appalling, being 95 to 100 per cent, while the maternal mortality is about 50 per cent. In the milder cases the maternal morbidity and mortality is not much higher than in normal cases, where a prompt diagnosis is made and proper treatment is carried out. Keep the occurrence of ablatio placenta constantly in mind. When it occurs, remember that the hemorrhage may be concealed, and that *shock* is always present and often very severe.

This brings us to the point we should be particularly interested in, namely, the management of these cases. Naturally, the woman must be sent to the hospital; that is the only proper place to treat her. *Never* keep such a case *at home* for the delivery if you can possibly get her into a hospital. Once the diagnosis is made, delivery must be accomplished. The method or methods by which the pregnancy shall be terminated depend upon:

1. The condition of the cervix.
2. The size of the pelvis.

3. The size and position of the fetus

4. The contracity of the uterus.

If the patient is a multipara, with a soft, partially dilatable cervix, rupture of the membranes and a firm abdominal binder usually are all that need be done. Give morphine sulphate, one-quarter grain, to help combat the shock as well as to accelerate dilatation of the cervix. In addition, a few applications of nasal pituitrin, given every thirty minutes until uterine contractions are improved and maintained, is often of very great benefit. *Watch the patient carefully after giving pituitrin.*

In the primiparous patient the problem is still more difficult. If the cervix is partially dilated and is still further dilatable, rupture of the membranes with insertion of hydrostatic bag (Voorhees'), plus vaginal pack, will usually control further bleeding and labor will progress until delivery can be accomplished with the least trauma to the cervix. Version, and breech extraction, and forceps delivery are very dangerous, due to the added shock superimposed upon a patient already suffering from hemorrhage and shock. If all methods of delivery by the vagina are unwarranted, Caesarian section must be performed. Indeed, as Dr. Whitridge Williams has shown, even after delivery is accomplished, the uterus often fails to contract because of the profuse widespread infiltrating hemorrhage into its musculature. There is a paralysis of the uterine muscle, and post-partum bleeding is almost sure to occur. If this hemorrhage cannot be controlled by packing the uterus, administration of pituitrin, gynergin, ergotrate, etc., hysterectomy must be performed. Even after Caesarian section, hemorrhage is apt to occur, and hysterectomy may have to be done. The home, therefore, is not the place to treat these cases; the hospital is the only place for them.

Transfusion is almost always indicated, before and after delivery to combat the hemorrhage and shock, and later the anemia which invariably follows.

RUPTURE OF THE UTERUS

Rupture of the uterus during the last trimester of pregnancy occasionally occurs, and should therefore be considered, at least briefly,

in any discussion of hemorrhage during this period of pregnancy. Such rupture of the uterus may be either *spontaneous*, or *traumatic*—usually spontaneous.

The principal causes of this accident, excluding those after the onset of labor, are the following:

1. Scarring in the wall of the uterus—from curettage; from Caesarian section; from myomectomy; from plastic operations on the uterus; from manual removal of adherent placenta.

2. Fibroids in the wall of the uterus, particularly if degenerating.

3. Congenital malformation of the uterus (unicornis, bicornis, etc.).

4. Over-distention, especially in the presence of scarring as noted above, due to polyhydramnios or multiple pregnancy, etc.

5. Ablatio placenta.

6. Vento-fixation with extreme saculation of posterior lower uterine segment.

It has been said that, when spontaneous rupture occurs late in pregnancy, the tear is usually in the upper fundal area of the uterus; but only recently we have seen a spontaneous rupture in the lower posterior segment. It seems fair to state therefore that rupture may occur in any area of the uterus in which any of the etiological factors enumerated above are present.

Spontaneous rupture is always complete, all layers of the uterus being torn through.

The diagnosis may be easy or difficult, depending on the extent of the injury, its location, and the amount of hemorrhage and shock. If the rent in the uterus allows the fetus to escape into the peritoneal cavity, the diagnosis is easier because here the contracted uterus can be felt with the child free in the abdominal cavity. With the baby remaining in the uterus the diagnosis is clouded, although there is, sooner or later, sufficient intra-peritoneal hemorrhage to warrant *laparotomy*, which is the proper treatment for rupture of the uterus. In

some cases the rupture is followed by massive hemorrhage and profound shock, in which instance the diagnosis is easy and the treatment clearly indicated, viz.: treatment of shock, transfusion and laparotomy for hysterectomy; or in an occasional case in a young woman, repair of the injury, retaining the uterus.

In many of these ruptured uterus cases the baby is "dead on arrival". There are cases, however, in which the placenta is not disturbed by the rent in the uterus; the hemorrhage and shock are not too severe; and, where prompt laparotomy is performed, the baby is delivered alive.

CONCLUSIONS

In conclusion, I should like to leave these thoughts with you:

1. Hemorrhage during pregnancy is a serious complication and therefore calls for prompt diagnosis and immediate intelligent management.

2. In hemorrhage during the last trimester of pregnancy, the patient should be hospitalized where every facility is at hand for the proper management of the case.

3. Provision for blood transfusion should be immediately made in every case of hemorrhage during the last trimester of pregnancy. Valuable time may be lost—and perhaps the patient's life—if such precaution is not taken.

4. When the hemorrhage has been sufficient to cause shock, the quicker the shock is treated, the better the chances for recovery.

5. Asepsis must be rigidly observed in dealing with hemorrhage during any period of pregnancy, but particularly during the last trimester, as puerperal sepsis is a very frequent complication of rupture of the uterus, ablatio placenta and placenta previa.

6. All hemorrhage deaths are catastrophies which remind the elder physicians and obstetricians of their responsibilities, and the younger aspirants of the need for more and better preparation.

THE PRESIDENT'S PAGE

NUMBER EIGHT

THE MID-YEAR OUTLOOK

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

An address to the Welfare Committee, at its regular meeting on the afternoon of Sunday, December 4, 1938, in the Hotel Hildebrecht, Trenton, N. J.

This meeting marks the close of the first and the beginning of the second half of this administrative year; and the stream-line Medical Society of New Jersey is running right on scheduled time.

At the beginning of the year, definite objectives were formulated and a schedule of work was laid out month by month. At the time, some feared that the proposed program was too comprehensive, and that we were asking too much of our committeemen. In order to distribute the load, the work was divided among two hundred men, each of whom pledged his services in writing. The attendance and interest at the various meetings of the committees have set a new high in organized medicine. The Medical Society of New Jersey has captured more interest and better attendance from more committeemen than any other state medical society anywhere, and at any time; and the thinking of its members has been clear and their activities constructive.

COMMITTEE MEETINGS

At the beginning of the year, committee meeting dates were fixed and a budget built accordingly. Many of the committees have become so interested that they are asking for extra meetings. All of these extra-curricular meetings are desirable. Some of them are essential. For the sake of economy, let us limit committee meetings to the original schedule where possible. But I do not believe for one moment that there is a single dues-paying doctor in New Jersey who would want us to sacrifice efficiency for parsimony.

LEGISLATION

What of the second semester? We must decide whether or not to reintroduce a Medical Practice Act (last year's Assembly Bill Number 511). Personally, I believe such a bill should not be introduced unless it can be re-drafted to meet the enthusiastic support of the entire profession. Last year some of the component societies gave A-511 lip service only. Oh, they went along. While such loyalty deserves commendation, legislators were quick to sense the fact that medical support of the Act was not universally whole-hearted. If the Welfare Committee and the Trustees decide to

introduce a basic practice law, let us send flying squadrons of informed medical men to every county where there is any question about the proposed bill; and let us employ a salaried secretary of the legislative committee. If we do it, let's do it right. But first of all, let us decide among ourselves exactly what we want to do. I do not propose to stand by and see busy doctors neglect their practices at home to appear day after day in Trenton in our behalf and work their hearts out to secure the passage of any bill that does not have the earnest, undeviating support of the entire profession.

Stripped of legal phraseology, the bill makes four essential changes in the present practice act.

1. Only citizens of the United States will be eligible to take the New Jersey State Board examinations to practice medicine. The mere declaration of intention of becoming citizens will not be enough.

2. All who practice the healing art must have the same preliminary high school and college training, and must have competent laboratory training in the basic fundamentals of diagnosis, anatomy, physiology, and pathology.

3. The new act will put teeth into the law against violators of the Medical Practice Act. Violators will no longer pay a small fine and repeat the offence at will.

4. The new act will prohibit the *corporate practice of medicine* except under the present provisions of the Workman's Compensation Act, and examinations by insurance and school physicians.

Personally I am heart and soul in favor of this bill, and believe we owe it to the people of New Jersey, to ourselves, and to friendly legislators to reintroduce it. For A-511 some assemblymen risked their political future. We ought not fail them now.

VISITING COUNTY SOCIETIES

The members of the Cabinet,—Drs. Hawkes, Morris, Lewis, and your President,—in their official visits to the county societies, are making careful studies of organization structure, and are submitting detailed reports, together with their constructive suggestions which are followed up by correspondence. The county societies are coming to understand that the

State organization is doing its level best to help them with their problems. Every county except Salem, Somerset, and Sussex have been visited already, and the first half of the year is just finished. In all, the Cabinet has made thirty-nine visits. I hope every county society avails itself of the offer of the Officers of the State Society to install the newly elected county society officers.

Your President has visited eleven county societies. The work of every one of them without exception is marvelous. Everywhere there is abundant evidence of interest in scientific advancement, and in the maelstrom of economic problems that threaten to engulf us. But there are too many doctors who are saying, "Something ought to be done about it", and yet these very men themselves are in abysmal ignorance of what the State Society and its Welfare Committee are doing for them. The Journal chronicles their achievements, but in spite of accurate and attractive reporting, too many members do not read the Journal. Let me urge you, therefore, once more to carry back, by word of mouth, to the next meeting of your county society the story of what your State Society is doing. So far as I know, not one single suggestion has ever been made by any member of The Medical Society of New Jersey that has not received immediate, full, sympathetic and thoughtful consideration.

NEXT MEETING OF WELFARE COMMITTEE

The next meeting of the Welfare Committee will be held in Trenton on February 19th. You will be privileged to hear one of the outstanding addresses of the year by Dr. Haven Emerson. Let us not only bring the officers of the component county societies with us to that meeting, but let us bring along an automobile loaded with selected men who would benefit by a visit to the Welfare Committee. One glimpse of the Welfare Committee in action will transform the skepticism of a doubting Thomas into the evangelical zeal of a St. Paul.

GOVERNOR'S HEALTH AND WELFARE COMMITTEE

The organization of Governor Moore's New Jersey State Committee on Health and Welfare is progressing along sane lines. I believe it will demonstrate what the National Health Conference failed to show—that sanity and altruism are not incompatible and that a conference is an *interchange* of views. The organization meeting of the New Jersey Committee was held on November 16th in the State House. The doctors on the committee had met previously and knew what to expect. Governor Moore outlined the duties of the committee:

First, to study the five proposals of the National Health "Conference".

Second, to determine the health needs of New Jersey.

Third, to correlate the two.

Dr. Robert Clothier, President of Rutgers University, was made Chairman. On November 29th, with the help of Dr. Kler, Dr. Wilkes, Mr. Ellis, Mr. MacDonald, and your President, Dr. Clothier made tentative committee appointments. On each of the committees, The Medical Society of New Jersey is well represented.

The committee appointments are as follows:

Executive—Dr. J. H. Kler, Chairman
Dr. George O'Hanlon Dr. W. J. Carrington
Public Health—Dr. Stanley Nichols, Chairman
Dr. A. S. Knight Dr. A. L. S. Stone
Dr. J. Lynn Mahaffey
Child and Maternal Health—Dr. Julius Levy, Chm.
Dr. A. W. Bingham Dr. S. Cosgrove
The Blind—Dr. E. A. Curtis, Chairman
Dr. E. S. Sherman
Tuberculosis—Dr. B. S. Pollak, Chairman
Dr. S. B. English
Venereal Disease—Dr. Karl Scott, Chairman
Dr. C. B. Blaisdell
Cancer—Dr. J. H. Kler, Chairman
Dr. William Areson Dr. Edgar Ill
Dr. Emil Frankel Dr. Asher Yaguda
Dr. W. G. Herrman
Pneumonia—Dr. C. V. Craster, Chairman
Dr. R. A. Kilduffe Dr. J. W. Gray
Mental Diseases—Dr. J. Raycroft, Chairman
Dr. I. W. Knight Dr. G. Stevenson
Dr. J. Plant
Industrial Diseases—Dr. L. D. Bristol, Chairman
Dr. Edgar Evans Dr. H. Kessler
School Health—Dr. A. G. Ireland
Dr. H. Silver Dr. R. Wing
College Health—Dr. W. York, Chairman
Dr. R. Greenwood
Hospital Facilities—Dr. E. Guion, Chairman
Dr. T. K. Lewis
Indigent—Dr. S. T. Snedecor, Chairman
Dr. G. W. Fithian Dr. Ellen Potter
Dr. F. Lee Dr. L. A. Wilkes
Low-Wage Group—Dr. Augustus Knight, Chm.
Dr. H. S. Read
Wage Loss Insurance—Dr. A. F. McBride
Dr. J. M. Rector

I have taken time to mention these tentative appointments for two reasons:

First, to urge you who have been appointed to accept;

Second, to show the striking contrast between the national and the New Jersey set-up,—the Federal program having been planned without the counsel and advice of a single practicing physician. Here we are in New Jersey, face to face with a great medical crisis, ready and set to go. If ever a President felt

proud of his Society, I feel proud of mine. Governor Moore has turned to organized medicine for leadership in medical matters. We cannot fail him or the people of New Jersey. Some city health officials interpreted the recommendations of the National Health Conference to mean that they are to be in the saddle. At least one of them here in New Jersey prefers to hire "Poor doctors" on salaries to care for the indigent. That plan is undoubtedly cheaper than permitting indigent free choice of physician, with reimbursement along the lines laid down under E. R. A. rates with tax money. I believe the New Jersey Health and Welfare Committee will recommend the far more efficient and humane plan of free choice of physician to the indigent.

DISTRICT COUNCILOR MEETINGS

In order to establish friendly understanding between the profession and our law makers, the District Councilors were asked to arrange inter-county meetings with assemblymen, and State senators and representatives as honored guests. Dr. Ulmer's meeting of the Fifth District in Bridgeton on November 15th, and Dr. Fuhrmann's of the Third District in Princeton, were well arranged and well attended. Both deserve our sincere thanks. Dr. Hawkes arranged a luncheon for the lawmakers and the officers of the county societies in Dr. Beling's district—the First; and Dr. Lewis completed the arrangements for a meeting in Dr. Fisher's district, which was held at Silver Lake Inn at 9:00 p. m., December 13th. Dr. Butler's meeting of the Second District was

held in Jersey City at 9:00 p. m. on the evening of December 15th, at which Drs. Read and Fishbein were both on the program.

MEDICAL HISTORY

A word about the History of The Medical Society of New Jersey. Dr. Overton tells me that he is securing excellent coöperation from county historians and the Woman's Auxiliary and that he will have the History ready for the printer before our next Annual Meeting.

THE 1939 ANNUAL MEETING

Drs. Kaighn and Andrews are building a program that will reach a new high for the next Annual Meeting, which will be held in Haddon Hall, Atlantic City, June 6th, 7th, and 8th, 1939.

FALL CLINICAL CONFERENCE

Since the Welfare Committee last met, the first Clinical Session of The Medical Society of New Jersey has become a matter of history. Its success exceeded our most sanguine expectations. We are forever grateful to Dr. Gauch and his colleagues on the Essex County committee for their hospitality and for the excellence of the clinics, ward walks, and demonstrations. Approximately 1,000 physicians attended the various sessions.

I hope that next year Hudson County will invite us to hold our second Clinical Session in the Medical Center.

In closing, let me remind you that it is 2:15 p. m. We are precisely on time, and all is well.

COMMITTEE OBJECTIVES

OBJECTIVES OF THE COMMITTEE ON POST-GRADUATE EDUCATION

By DAVID FULLER BENTLEY, M.D., Chairman, Haddonfield, N. J.

Your Committee on Post-Graduate Education greatly feels the loss of our Chairman, Dr. Satchwell, and has undertaken to continue the work which he had so ably promoted, with some misgivings.

THE 1938-1939 COURSES

This year we hope to continue courses in four centers, namely Camden, Mercer, Somerset, and Atlantic Counties, with the coöperation of Rutgers University, and the able assistance rendered by Dr. Miller and Dr. Light of the University's Extension Division.

We hope these courses will prove just as beneficial and even more popular than those previously held. The course in Camden has already been started, and one meeting has been held at which there was an attendance of approximately ninety men. Chairmen in the other counties who are members of this committee have expressed hope that the courses will be repeated this year. This would mean that approximately three hundred physicians in the state will be taking courses in Post-Graduate Medicine, under the direction of the Rutgers University Extension Division.

We are contemplating making a survey of the number of men in the State, who as individuals, are taking post-graduate instruction, either in specialities or general medicine. This will probably be done by questionnaire.

SPEAKERS FOR COUNTY SOCIETIES

We have offered the use of the Post-Graduate Committee to any County Society in the State who may feel that, through us, some desirable speaker may be obtained for its meetings. Dr. Light of the Rutgers Extension Division has interested himself in this phase of the work, and feels that any of the members on the post-graduate faculty might be available for this purpose.

The Executive Office in Trenton keeps a file regarding courses of instruction that are available in New Jersey and in other states, particularly information and announcements coming to it through the American Medical Association. This information will be available to any member who requests it from the Executive Officer, 143 East State Street, Trenton, N. J.

The post-graduate work in the upper part of the State, we understand, will be undertaken by the local county societies; and while no official notice has been sent the committee, we have learned that clinics and lectures are

contemplated in Hudson, Essex, and possibly some of the other counties.

THE FALL CLINICAL CONFERENCE

The committee was greatly impressed by the success of the first clinical conference which was held in Newark this Fall, and feels that every effort should be made to continue these meetings and to broaden their scope. We realize the importance of placing post-graduate programs before our membership, and regret that the facilities offered are not utilized by many more of our members.

PUBLIC HEALTH SUBJECTS

We have coöperated with the Committee on Public Health, and one of our members regularly attends its meetings so as to keep us in touch with its activities. We are endeavoring to introduce subjects which pertain to public health, and thus assist somewhat the Public Health Committee's program.

We have endeavored to exemplify the standards expressed by President Carrington—that every member of the New Jersey Medical Society undertake to secure for himself some post-graduate instruction each year;—but in addition to the lectures and courses sponsored directly by the committee, each county society makes scientific instruction a prominent feature of its program of nearly every meeting.

PROGRESS OF THE PNEUMONIA CAMPAIGN

By ROBERT A. KILDUFFE, M.D., Chairman, Atlantic City, N. J.

Since the pneumonia program has passed its organization stage and is actually functioning, it seems profitable, at this half-way mark, to take stock of its accomplishments.

The establishment of a network of typing and serum distribution stations throughout the State is past history (Jour., Aug., p. 513, and Oct., p. 644), and now we may well ask, "To what extent have these facilities been used?"

Thanks to the mild weather, the incidence of pneumonia has thus far been low. Nevertheless, up to November 30, a total of 187 cases have been treated with serum supplied by the State. This, of course, indicates a definite activity on the part of the typing stations, which have done many more than 187 sputum typings. It is not amiss to note that these stations have not received typing serums for the

State, nor any recompense for their time, labor, or skill expended in this work.

In general, the incidence of the pneumococcus types has followed the usual frequency.

Types I, VIII, and III have been the most frequent in the order that is given. Other types have occurred in the following order of frequency: Types VI, IX, VII, and XIV. Types II, XIII, XXIX, and XXII have been rather infrequent and scattered.

From the reports turned in by the attending physician at the termination of the case—the *only* source, it may be emphasized, whereby the results of the campaign can be followed,—the following data appear:

From 115 such reports, it is shown that the incidence of pneumonia in the male is approximately three times that of the female. In the 115 treated cases there were twenty deaths, an incidence of 16.8 per cent.

The type incidence and mortality of the cases for which complete reports are available follow:

Type	Cases	Deaths
I	60	7
II	27	4
V	8	1
VII	8	2
VIII	12	1
Total	115	16

It is of practical interest to note that the average duration of the disease before serum treatment was begun in the fatal cases was three days; in the whole series, 5.5 days.

The relation between the *early* institution of serum treatment and the results is clear, and should not need further and repeated emphasis. The earlier the treatment is begun, the better will be the results—and the smaller the amount of serum that will be required. The State expenditure for serum treatment has so far averaged about \$800 per week.

As part of the educational program of this campaign the motion picture on pneumonia has

had over 200 showings, with more to follow; county medical societies have had pneumonia programs; and many hospital staffs have given one or more meetings to this subject. Many more such meetings will follow.

As is known, pneumonia is a reportable disease; but prior to the inauguration of this program, there had been no widespread observance of this regulation, since no particular application of the knowledge could be made. Now that the program is under way, however, it is of definite importance and interest that this regulation regarding reporting cases should be carried out.

The Pneumonia Program Committee therefore requests the coöperation of the physicians of New Jersey in the following respects:

1. *Report all your pneumonia cases* to your local Board of Health, stating the type whenever possible.

2. Utilize the State facilities for *serum treatment*.

3. *Complete the report blank* at the termination of the case.

This is all that is asked of you in return for the serum, and is the only means whereby the results of the campaign can be known.

COMMITTEE ON WORKMEN'S COMPENSATION

By HARRY N. COMANDO, M.D., Chairman, Newark, N. J.

The present compensation law in the State of New Jersey is a fairly good one, although in the administration thereof a great many abuses have crept in. A new law should have as its important factors or amendments:

1. The injured worker or the one suffering from an occupational disease should have the right to select his own physician.

2. Industry should be fully protected against incompetence or excessive costs by the following safeguards:

a. The employee should have the right of consultation by his own physician at all times.

b. It shall be the duty of the doctor treating the case to inform the employer in writing, promptly. This notice to include, the name, age, and address of the patient; a tentative diagnosis and prognosis; where the patient can be found at that particular time (home, hospital, etc.).

c. In cases where consultations between the employer's and employee's doctor fail to effect an agreement, an immediate consultation with

one of the State doctors shall be called. The State doctor shall have the final say as to the disposition of the case. (These State doctors should be full-time men, forbidden to do any private practice; and there shall be one or more for each compensation district in the State.)

d. All contested bills should be settled by a board of arbitration, the members of which shall be appointed by the appointing powers of the State. The members of this board shall be paid out of funds assessed against parties of the contested bill.

All clinics conducted by insurance carriers and manufacturers should cease caring for injured or diseased workers, except for first-aid or emergency treatment.

This committee has made such progress that it is desirable to meet with representatives of labor, employers, insurance carriers, etc., and try to adjust their plans in a way that will be desirable to everybody concerned. Such meetings are now in the making, and we hope to have a new act, or a revised act, ready for presentation soon.

STATE SOCIETY ACTIVITIES

WELFARE COMMITTEE

A meeting of the Welfare Committee was held in the Hotel Hildebrech, Trenton, N. J., at 2 p. m., December 4, 1938, following a meeting of each of its component committees, as announced on pages iii to vii of each issue of The Journal. Chairman Hilton S. Read presided and fifty-two members were present, as follows:

Atlantic County:

Hilton S. Read, Chairman
William J. Carrington, President of the State Society, Ex-Officio

David B. Allman Robert A. Kilduffe
Homer I. Silvers

Bergen:

G. Barton Barlow Walter J. Farr
Charles Littwin Spencer T. Snedecor

Camden:

Ernest G. Hummel R. L. Sharp

Cape May:

Harry B. Walker

Cumberland:

Millard F. Sewall Leslie E. Myatt

Essex:

Alfred Stahl, Secretary of the State Society,
Ex-Officio

Arthur W. Bingham Harry N. Comando
Edgar P. Cardwell A. Charles Zehnder

Gloucester:

Chester I. Ulmer Wendall J. Burkett

Hudson:

A. E. Jaffin Joseph F. Londrigan
B. S. Pollak

Hunterdon:

Barclay S. Fuhrmann

Mercer:

D. Leo Haggerty Charles H. Mitchell
Allen G. Ireland

Middlesex:

Henry Haywood, Jr. Jacob J. Mann
Joseph H. Kler William C. Wilentz

Monmouth:

C. Byron Blaisdell Barclay W. Moffat
J. Berkeley Gordon Stanley Nichols
William G. Herrman

Morris:

Byron G. Sherman

Ocean:

Eugene G. Herbener

Passaic:

Wright MacMillan Frank Ash
Sigurd W. Johnsen J. Allen Yager

Somerset:

Frank L. Field

Sussex:

James H. Spencer, Jr.

Union:

Norman W. Burritt Herschel S. Murphy
Frederic W. Lathrop

Advisory members:

William H. MacDonald, representing the State Department of Health
Robert P. Fischelis, representing the State Pharmaceutical Association
LeRoy A. Wilkes, Secretary
Frank Overton, Editor

The minutes of the last meeting of the Welfare Committee on October 2nd were approved as published in the Journal of November, 1938, page 682.

MEMORIAL OF DR. MCGUIRE

A moment of silence was observed in memory of Dr. James J. McGuire, former Secretary of the State Board of Medical Examiners, who died on October 11, 1938.

PRESIDENT'S ADDRESS

Dr. William J. Carrington, President of the Society, gave an address, which is printed on the President's Page (page 34).

LEGISLATION

Dr. Pollak: The Legislative Committee unanimously recommended to the Welfare Committee the favorable consideration of the reintroduction in the next legislature of the revised Uniform Medical Practice Act. Following discussion by Drs. Haggerty, Herrman, Carrington, Alexander, Ulmer, Sharp, MacMillan, Kilduffe, Yaguda, Field, Lathrop, Nichols, Eagleton, Brennock, Londrigan, McBride, Newcomb, Varney, Marsh, and Pollak, Dr. Brennock moved that the report of the

Legislative Committee be tabled until the next meeting of the Welfare Committee. The motion was seconded and carried.

It was voted that "Flying squadrons" be sent to each county society to inform the members of the bill, and to determine whether or not the county societies will support it. This is to be reported at a special meeting of the Welfare Committee to be held on January 8th, at 2 p. m., at which 100 per cent attendance is requested.

TUBERCULOSIS

Dr. Jaffin presented the reply, prepared by his committee, to Dr. Ireland's questionnaire on tuberculosis case-finding in the public schools. It was explained that the purpose of this was for advising school physicians and lay school officials. Dr. Jaffin moved that the Welfare Committee approve the reply as presented. This motion was seconded and unanimously carried.

PNEUMONIA CONTROL

Dr. Kilduffe reported that the work of typing pneumonia cases and distributing serum is still being carried on, and an educational campaign is being presented to the public through motion picture films, and to the doctors through pneumonia programs in the county societies.

It was moved by Dr. Kilduffe, seconded and unanimously carried that the Welfare Committee approve a request being made to Governor Moore by the Pneumonia Committee in conjunction with the Department of Health, for an additional appropriation to carry on the work of distributing serum since the fund is now almost completely exhausted in stocking the stations with serum.

CANCER CONTROL

Dr. Herrman, Chairman, reported that the resolutions from the various County Boards of Freeholders recommending the building of the State hospital for the care and treatment of indigent cancer cases had been rejected by the committee. He also reported that the committee had approved the Curie Institute *in principle*. The government announced that it is prepared to loan radium to institutions which have been approved by the State Department of Health for the loan. The loan is for a maximum of one year, and the institution is required to put up a bond to cover the value of the radium. The institution must also pay the insurance and transportation charges. The next move of the committee is to meet with the chairmen of the County Cancer Control Committees, and develop a cancer program in each county society.

SUB-COMMITTEE ON MEDICAL PRACTICE

Chairman Allman reported that his committee had held a very successful meeting on November 20th, at which a complete committee report was given by each of the advisory committees, which is printed on page 41 of this Journal. All the committees are hard at work, and much progress is being made along all fronts for the preservation of private practice, and for the protection of organized medicine.

Dr. Allman called on Dr. Ulmer, Chairman of the Committee on *Pharmaceutical Problems*, who reported that copies of the New Jersey Formulary had been sent to all members of the Society.

SUB-COMMITTEE ON PUBLIC RELATIONS

Dr. Kler, Chairman, reported that the work of the Sub-committee on Public Relations was progressing satisfactorily, and urged the need for speakers to talk about *medical economics* and not socialized medicine. There are many lay groups interested in this subject, and it was urged that in the County Public Relations Committees medical economics be stressed. There will be a report of the Public Relations Committee in the Journal.

MEDICAL INSURANCE

Dr. Read reported on the Special Committee on the *Study of Medical Cost Insurance*. This was a fact-finding committee, and after study and conference with several authorities on medical economics, Dr. Leland, Chairman of Public Relations of the Medical Society of the State of New York; Dr. Michael Davis, and Dr. Elliot, the committee is about to recommend that a committee be appointed to devise some plan of voluntary indemnity insurance to be tried as an experiment in certain picked areas in the State.

PUBLIC RELATIONS AT THE ANNUAL MEETING

Dr. Kaighn, Chairman of the Committee on the Annual Meeting, offered a plan of the President for Wednesday evening of the Annual Meeting. It has been suggested that an open forum be held with prominent representatives of labor, perhaps Mr. Green; a prominent author, perhaps Dorothy Thompson; a representative of the official family, Mrs. Roosevelt; a country practitioner; a representative of public health, perhaps Victor Heiser; etc. These speakers would be invited to give their impression of the American Doctor. It was also suggested that an orchestra of reputation be obtained for this meeting. It would

cost between \$1500 and \$2000, but would not be confined to New Jersey as there would probably be a large radio audience. The Trustees will of course have to decide whether or not they wish to spend this much money for such a program.

FARM SECURITY ADMINISTRATION

Dr. Allman asked for action on the resolution of the *Farm Security Administration* for Medical Care (Jour., Nov., 1938, p. 684). The Farm Security loans money to farmers which is placed in a pool under the care of a trustee, and from this physicians' bills are paid for services to those who belong to the pool.

Dr. Londrigan moved that the Welfare Committee approve this plan in principle and send

it to the county societies for action. This motion was seconded and carried.

FEE FOR PREMARITAL CERTIFICATES

It was regularly moved, seconded, and unanimously carried that three dollars is an average fair fee for taking a Wassermann blood specimen and filling out the required medical certificate.

FOOD AND DRUG ACT

Dr. MacMillan requested that the President authorize the Food and Drug Committee to investigate the new Food and Drug Act which has been passed, to see how much of what we advocated has been included.

The meeting adjourned at 4:00 p. m.

LEROY A. WILKES, M.D., *Secretary*.

MEDICAL PRACTICE COMMITTEE

A meeting of the Medical Practice Subcommittee of the Welfare Committee was held on Sunday, November 20th, 1938, at 10 a. m., in the Hotel Ambassador, Atlantic City, N. J. Those present were:

David Allman, Chairman, who presided

Committee members:

S. T. Snedecor	W. W. Maver
H. N. Comando	R. L. Sharp
G. W. Fithian	C. I. Ulmer
J. I. Fort	A. C. Zehnder

Dr. LeRoy A. Wilkes, Executive Officer and Secretary to the committee

Dr. Norman M. Scott, Executive Assistant

FARM SECURITY ADMINISTRATION

The proposed plan by the Farm Security Administration for medical care to be given by local physicians was explained by Mr. Danenhauer and Mr. Hoyt from the central office of the Administration. This plan proposes that out of the Federal money loaned to the farmers, depending upon the size of the family, from \$16 to \$20 (plus \$10 extra when there is a confinement case) be placed in a pool under the care of a Trustee. From this fund doctor bills are paid. The doctor charges the regular fees which he would charge for any person with a low income, and sends the bill to the Trustee, who, before payment, turns it over to a committee of The Medical Society of New Jersey for review. The bills are paid in full unless there have been such excessive costs that month that the fund cannot cover the bill. The farmer has the privilege of choosing his own physician. Anyone approved for a standard loan may become a part of this pool. Hospital-

ization and surgery are not included in this plan. There will probably be one Trustee in each county,—someone approved by the Medical Society. The doctors have the privilege of setting up rules and regulations for this system. (Journal, November, 1938, p. 684.)

After discussion, a motion was made by Dr. Sharp, seconded and unanimously carried, that the Farm Security Plan be approved in principle by this committee, and that it be referred to Dr. Fithian's committee, with Dr. Allman and Dr. Lewis as consultants; and that the plan be put on a state-wide basis rather than a county basis.

ADVISORY COMMITTEES' REPORTS

The reports of nine advisory committees were received and discussed.

1. WORKMEN'S COMPENSATION

Dr. Comando reported on the recommendations of his committee which would be included in amendments to the present law, or in a new Workmen's Compensation Law. These included free choice of physicians; an arbitration board for disputed bills, full-time state doctors having the right of decision in contested consultations; easily obtained consultations and examinations concerning the injured person; separation of hospital and doctor fees in a hernia case, with the doctor's fee \$100; a list of all compensable dermatosis; a commission of doctors and lawyers to scrutinize testimony; and the right to force appellate courts to hand down decisions within a reasonable time—sixty to ninety days.

The Medical Practice Committee recommended that the Workmen's Compensation Committee meet with representatives of labor, industry, insurance companies; and after this conference, present recommendations to the Legislative Committee, who will refer them to the Medical Practice Committee; and this committee in turn will refer them to the Welfare Committee.

2. NURSING AND NURSING EDUCATION

Dr. Zehnder reported that courses for "nursing attendants" have been established in three vocational schools, but that there have not been the number of applicants for this course as had been hoped for. The committee is now ready to consider whether the didactic instruction of the pupil nurse for the Graduate Nurses' Training Schools can be given before she enters upon her bedside instructions.

At the request of Dr. Zehnder's committee, the Medical Practice Committee recommended that Mr. McCarthy of the Department of Education, and Mr. Beebe of the Essex County Vocational Schools, be invited to attend the next meeting of the Committee on Nursing and Nursing Education to discuss this proposition. At a subsequent meeting representatives of the nurses will be invited, in order to obtain their point of view. At a third meeting both groups will be asked to attend.

3. CONTRACT PRACTICE

Dr. Sharp read a contract between a department store and a physician for the medical care of the employees of that store, as an example of the type of contract work that prevails. This was on a salary basis.

Dr. Sharp recommended that there be some very definite rules developed to determine what is an ethical contract. Some general plan must be developed for the State which can be presented at the next annual meeting.

The committee recommended that the principles adopted by the A. M. A. Judicial Council be adapted to New Jersey, and be presented to the counties as guiding principles, as the county will in the last analysis decide the procedure to be followed.

4. HOSPITAL RELATIONSHIPS

Dr. Snedecor reported that the committee had sent a letter to each hospital in the State urging conferences with the staff and the other hospital groups, superintendents, trustees, medical boards, etc., be held sometime during the year.

The hospital survey is not quite completed, and therefore no report is yet available.

5. MEDICAL CARE OF THE INDIGENT AND LOW-WAGE GROUP

Dr. Fithian reported that his committee had been unable to accomplish anything because of the lack of funds, and of the necessary legislation to provide funds. The committee would like to see some plan similar to the old E. R. A. plan enacted.

When the Committee on the Study of the Cost of Medical Care Insurance has completed its work, the material will be turned over to Dr. Fithian's committee. The work of the Governor's committee will, no doubt, aid the Committee on Medical Care of the Indigent and Low-Wage Group.

6. AUXILIARY MEDICAL SERVICES

Dr. Maver reported that his committee is trying to extend auxiliary medical services to bring them within the reach of the low-income groups. Committees are working in the Clinical Pathology Society and the Radiological Society on a plan by means of which it is hoped to bring these services at reduced rates to the low income classes.

The Auxiliary Medical Services Committee made certain recommendations regarding what was felt to be a practical way of meeting hospital insurance insofar as the auxiliary medical services were concerned, and they were endorsed by the Society; but nothing further was done, and the committee would like some recommendation from the Medical Practice Committee.

It was suggested by the Medical Practice Committee that this can probably be written into a medical cost insurance policy after this insurance has developed further. Until then it will have to be left in the hands of Dr. Herrman, who represents the Medical Society, and Dr. Sprague, who is also on the Hospital Insurance Board.

7. PHARMACEUTICAL PROBLEMS

Dr. Ulmer reported that the New Jersey Formulary had been sent to each member of the State Society.

It is the recommendation of the Pharmaceutical Committee that each county society next year arrange a joint meeting of physicians and pharmacists in order to promote a more co-operative understanding between the professions.

Dr. Zehnder requested that in the next Formulary a formulae for an eye-wash be included.

8. INDUSTRIAL INJURIES AND OCCUPATIONAL DISEASES

Dr. Fort reported that a questionnaire is being forwarded to various business and manufacturing organizations throughout the State in an endeavor to obtain information about industrial accidents and diseases. Some information is being obtained through insurance carriers. Regulations of the Department of Labor which apply to safety devices, hygiene, and inspection are being studied.

It was regularly moved, seconded and carried that the Medical Practice Committee go on record in favor of sending this questionnaire to the business and manufacturing organizations.

It was suggested that a similar questionnaire, to be filled out by representatives of labor, be prepared. It was also suggested that on the questionnaire to business and manufacturing organizations some statement be made that the findings of the questionnaire will be reported to any organization so desiring this.

9. MEDICAL COST INSURANCE

The Committee on the Study of Medical Cost Insurance was appointed by Dr. Carrington as a fact-finding committee. At the organization meeting each member of the committee was asked to seek some special type of information to find out just what the people want. Dr. Leland, of the A. M. A., came to a meeting of the Welfare Committee on June 5th,

1938, to offer his suggestions and criticisms. The plan prepared by Dr. Elliot, which was presented to, but not accepted by, the King's County Medical Society, was discussed. The cost of medical care insurance is \$14.60 a year with \$10 deductible, which makes the cost about \$25 per year for medical care. It is felt that this plan will not meet with the enthusiasm of hospital insurance because it is on an individual basis, and because people are more willing to gamble with doctor bills.

Dr. Michael Davis and Mr. Van Dyke of the New York Hospital Insurance Plan attended one of the meetings, and reported that New York is going into some sort of medical cost insurance, called the Ward Plan. They want something which will reach the semi-indigent group which, they admit, the hospital insurance plan is not doing.

Dr. Davis recommended that in New Jersey one or two experimental areas be chosen in which to try a voluntary indemnity insurance plan.

When this committee has completed its findings, the work will be turned over to the Committee on the Medical Care of the Indigent and Low-Wage Group.

It was suggested that the work of the Committee on Medical Cost Insurance be presented to the Welfare Committee, as most of our members know nothing of what has been done.

The meeting was adjourned at 3:00 p. m.

LEROY A. WILKES, M.D., *Secretary*.

COMMITTEE ON CANCER CONTROL

A meeting of the Committee on Cancer Control was held on November 8th, 1938, at 6:30 p. m., in the Stacy-Trent Hotel, Trenton. Those present were Dr. Herrman, who presided; Dr. Davidson, Dr. Faison, Dr. Holters, Dr. Kler and Mrs. Peabody; and also Mr. MacDonald, of the State Department of Health.

CURIE INSTITUTE

At the request of the chairman, Mrs. Peabody, representing the Curie Institute, was present to outline the plan of the Curie Institute to establish a central hospital, probably in or near Newark, to be devoted entirely to the treatment of cancer and allied diseases with the latest in radiation therapy apparatus, this central hospital to be used both for the treatment of patients living near the institute and cases from other parts of the state needing specialized care; the institute also to engage in research work. For the benefit of the rest

of the state, a large amount of radium will be owned by the institute, some of which, in the form of needles and tubes, will be loaned or rented at a very low charge to affiliated groups hereafter to be established or recognized in connection with qualified general hospitals. It is planned also to give or sell at a low charge radon implants, and to provide at this central hospital consultation service, and lectures for the rest of the state. The services of both the central and the affiliated groups will be for all classes, and charges will be adapted to the financial condition of the patients.

The Curie Institute also hopes to establish small *nursing homes* for the care of homeless and hopeless cancer cases, whether they are indigent or not.

The preliminary work of organization is still going forward, with the formation of lay groups in the various centers to interest themselves in the movement and raise funds.

The committee went on record as being in

favor of the principles of the Curie Institute, but as yet there are many points to be settled in regard to personnel, organization, and affiliation before the committee would recommend unqualified approval of the entire project; but the committee did feel that members of the State Society could associate themselves with the formation of Curie Aid groups, and help to guide the future development of the Institute, whose objectives they heartily approve.

NATIONAL CANCER ACT

Through the U. S. P. H. S., radium is to be made available for loan to states. The application of a hospital for radium must be sent to the Department of Health for approval before it is sent to Washington. Any institutions which meet certain qualifications may enter into an agreement guaranteeing that the radium will be protected, and that the institution will pay the transportation and insurance charges. It could be announced to each County Society when this Federal radium is available, and that interested groups should establish approved clinics.

It was suggested that institutions which have already started cancer clinics might benefit by loans of radium, and thus have the use of an amount of radium necessary for approval by the American College of Surgeons. It was also suggested that if a hospital could borrow enough radium it might equip itself to meet other qualifications and obtain approval of the hospital clinic by the College of Surgeons.

Mr. MacDonald, representing the State Board of Health, was present and was very anxious to have suggestions made as to the proper set-up for giving approval to application of particular institutions. While at the present time the amount of radium to be loaned in the State of New Jersey is probably small, it is felt that if we have the proper set-up arranged, it may be possible from time to time to obtain more radium from the National Can-

cer Institute. It was believed that the Cancer Control Committee of the State Society should act as an advisory committee to the State Board of Health when so requested.

CANCER COMMITTEE PROGRAM

The committee did not approve of the resolutions of the various Boards of Freeholders in regard to the establishment of a state cancer institution. We understand at the present time that some of the Boards of Freeholders are withdrawing such recommendations. The committee does believe that each county Board of Freeholders should make provision locally for the care of the homeless and hopeless cases, so that such cases will not in their last illness be widely separated from family or friends.

It was suggested that a General Cancer Committee be developed in each county, and controlled by physicians, but consisting of lay people also. This type of committee parallels the proposed Curie Aids. The success of having doctors talk to small groups of the laity has been definitely proven.

The committee believes that, as a unit of the State Society, it may perhaps best concern itself with principles and policies, and the investigation of such organizations or movements as the Curie Institute, rather than attempting a program to accomplish concrete results that are state-wide, inasmuch as the conditions vary so much in each county. It believes, however, that it should act to stimulate each County Society to establish a definite program applicable to each county, according to the local conditions. For this reason, it believes that there should be soon a meeting called of the chairmen of all the County Cancer Control Committees to meet with the committee of the State Society, and discuss individual programs for each county.

WILLIAM G. HERRMAN, M.D., Chairman,
Cancer Control Committee.

SECOND COUNCILOR DISTRICT

A meeting of the members of the Second Councilor District, composed of the Counties of Hudson, Bergen, Passaic, and Sussex, was held in Jersey City on the evening of Thursday, December 15, 1938, under the leadership of Dr. Vincent P. Butler, Judicial Councilor. The program began in the Carteret Club with a social hour at six o'clock, followed by a dinner with over fifty members and guests present.

A general meeting was held in the auditorium of St. Peter's College, Hudson Boulevard and Montgomery Street, with an attendance of over five hundred.

The program was as follows:

1. "Medicine in the News", William J. Carrington, M.D., Atlantic City, President, The Medical Society of New Jersey.
2. "Voluntary Medical Costs Insurance",

Hilton S. Read, M.D., Atlantic City, Chairman of the Welfare Committee, The Medical Society of New Jersey.

3. "American Medicine and the National Health Program", Morris Fishbein, M.D., Chicago, Illinois, Editor A. M. A. Journal.

FOURTH COUNCILOR DISTRICT

The members of the Fourth Councilor District, composed of the Counties of Monmouth, Ocean, Burlington, and Camden, held a social meeting in Silver Lake Inn, near Berlin, Camden County, under the direction of Judicial Councilor Dr. James A. Fisher, of Asbury Park. The guests included the wives of the doctors, and the members of the Legislature from the four counties of the District.

The program consisted of two brief addresses on the public relations of the medical profession of New Jersey. President William J. Carrington expressed the point of view of the physicians, and Mr. William H. MacDonald, that of the Department of Health.

The greater part of the evening was given over to informal sociabilities, including a continuous counter luncheon and dancing.

SPECIAL LICENSES TO PRACTITIONERS OF MEDICINE

In the Spring of 1938, a special bill relating to licensing practitioners of medicine was rushed through the Legislature over the protest of The Medical Society of New Jersey. It was introduced by Assemblyman DeVoe of Middlesex County on Monday, April 25, 1938. It was passed by the Assembly on Tuesday, April 26, and by the Senate on Tuesday, May third; and was signed by the Governor on May seventh.

The essential feature of the new law was

that graduation from any "legally incorporated medical or professional college in the United States" should be acceptable to the Board *whether or not the Board "approved" the standard of the institution*. The Board was therefore compelled to admit to the examination not only the particular candidate for whom the law was intended, but also four others in the same classification and to issue licenses to those who passed the examination.

The law expired on January 1, 1939, by its own provisions.

SOCIETY OF SURGEONS

The *Society of Surgeons of New Jersey* will hold its annual meeting and banquet in Newark on January 28th, 1939.

The morning clinical sessions will be held at St. Michael's Hospital and the Newark Eye and Ear Infirmary. The afternoon session and annual meeting will be held at the Robert Treat Hotel in Newark.

The President, Dr. George Blackburne, assisted by Drs. Edgar A. Ill, Bernard O'Conner, and Irving Fort, has arranged a series of operative cases and demonstrations at St. Michael's

Hospital; and Drs. Wells P. Eagleton, Henry Barkhorn and Charles Zehnder are arranging the sessions at the Newark Eye and Ear Infirmary.

Drs. Edward Sprague and Benjamin Fuhrmann are arranging the afternoon scientific session, which will consist mainly of motion pictures in color of various operations in general surgery.

The banquet will begin at 5 p. m., and Monsignor John Delaney, of the Board of St. Michael's, will give the invocation.

CHARTER OF THE SOMERSET COUNTY MEDICAL SOCIETY

In response to the appeal printed on page 750 of the December Journal, Dr. Lancelot Ely has sent a photostat copy of the charter of the Somerset County Medical Society which had been engraved on parchment at the expense of The Medical Society of New Jersey in 1904. A similar one had been sent to each of the other county societies at the same time. (Transactions, 1905, page 10.)

Dr. Ely also sent a photostat copy of the three pages of the minutes of the organization meeting of the Somerset County Medical Society, the first page of which is reproduced. The society stores its original minute book in the vaults of the County Clerk in Somerville.

Has any other County Society preserved its charter, or the minutes of its organization meeting?

Medical Society of New Jersey



Know All Men by These Presents

THAT by virtue of authority vested in the House of Delegates of this Society by its Constitution and By-Laws, a Charter is hereby issued to the Somerset County Medical Society, of which C.R.P. Fisher, M. D., is President, and J. Henry Buchanan, M. D., is Secretary, and to the members now belonging to such County Medical Society, and to their successors in perpetuity, with all of the honors and privileges pertaining thereto, so long as such Society conforms to the Constitution and By-Laws of the Medical Society of New Jersey.

GIVEN UNDER AUTHORITY of the House of Delegates, this 29th day of December, 1903.

Wm. J. Chandler, M. D.
RECORDING SECRETARY

Henry Littlehale, M. D.
PRESIDENT

Charter of the Somerset County Medical Society

MINUTES OF THE ORGANIZATION MEETING

The following minutes of the organization meeting of the "District Medical Society for the County of Somerset" are reproduced, as nearly as possible, in their original form, spelling, and punctuation.

Somerville, May 21st, 1816.

The following Physicians and Surgeons, agreeably to an appointment made by the "Medical Society of New Jersey", met at the house of Daniel Sargeant for the purpose of organizing the "District Medical Society for the County of Somerset" viz. Peter I. Stryker, Wm. McKissack, Augustus R. Taylor, Ferdinand S. Schenck, James Elmendorf, Wm. D. McKissack, Peter Vrendenberg and Fitz

Randolph Smith. They immediately proceeded to the election of their officers, agreeably to an act of Incorporation. The following gentlemen were chosen: Peter I. Stryker, President, Wm. McKissack, Vice-President, Ferdinand S. Schenck, Treasurer, James Elmendorf, Corresponding Secretary and Fitz Randolph Smith, Recording Secretary. The Society then took up and considered by sections a System of By-Laws proposed by Dr. Taylor, which

Somerville May 21st 1816

The following Physicians and Surgeons, agreeably to an appointment made by the "Medical Society of New Jersey", met at the house of Daniel Sargent for the purpose of organizing the "District Medical Society for the County of Somerset" Viz.

Peter J. Stryker, Wm McKrack, Augustus R. Taylor, Ferdinand S. Schenck, James Elmendorf, Wm D. McKrack, Peter Vreeland and Fitz Randolph Smith.

They immediately proceeded to the election of their Officers, agreeably to an act of Incorporation. The following gentlemen were chosen

Peter J. Stryker President, Wm McKrack Vice-President, Ferdinand S. Schenck Treasurer, James Elmendorf Corresponding Secretary and Fitz Randolph Smith Recording Secretary. The Society then took up and considered by sections a System of Reg. Laws proposed by Dr Taylor, which with amendments and

with amendments and alterations they adopted as the laws by which they are to be governed in their future proceedings. Dr. Taylor and Dr. F. R. Smith were appointed a committee to draw a fair copy of these laws and to have fifty copies printed.

On motion resolved that this Society consider it their province to appoint the examiners under the act of Incorporation, always paying proper respect to nominations made by the "Medical Society of New Jersey". The following members were then appointed "Censors" for the ensuing year viz. Drs. Stryker, Taylor, Elmendorf, Wm. McKissack and Smith. On motion Resolved that the Secretary be directed to have published in the Times and Fredonian a short minute of the organization of this Society, of their proceedings and of the manner in which candidates may in future apply for a license to practice Physic and Surgery. Resolved that the examiners are entitled to such compensation for their services as the Society may judge proper. On motion resolved that the first Thursday in May be considered as the

Anniversary of this Society. The President then appointed Dr. Taylor to deliver a Dissertation at the next stated meeting.

The following gentlemen were nominated as candidates for admission into this Society at their next regular meeting by Dr. Wm. D. McKissack viz. Abm. B. Hagaman and Henry L. Van Derveer and Dr. Perrine was proposed by F. R. Smith.

Resolved that the following be the order of business at all future meetings of the Society:—

Order of Business

- 1st Calling the Roll
- 2nd Dissertation
- 3rd Reading Minutes
- 4th Essays, Communications, Propositions, &c.
- 5th Reports of Committees
- 6th Choosing Officers.

The Society adjourned to meet at the house of Daniel Sargeant in Somerville at their next regular meeting.

Fitz Randolph Smith Secty.

INDICTMENT OF THE A. M. A.

The leading morning newspapers of Wednesday, December 21, 1938, featured the indictment secured by the Attorney General of the United States against the American Medical Association; the Medical Society of the District of Columbia; the Harris County Medical Society of Houston, Texas; and the Washington Academy of Surgery; and also twenty-one individuals including the following A. M. A. officials: Drs. Morris Fishbein, R. G. Leland, Olin West, and W. C. Woodward.

THE LAW

The Federal law for whose violation the indictment was found, is section 3 of the Sherman Anti-Trust Act, which prohibits "Every contract, combination in the form of trust or otherwise, in restraint of trade or commerce in any territory of the United States or of the District of Columbia * * * every person who shall make any such contract or engage in any such combination or conspiracy, shall be deemed guilty of a misdemeanor".

THE INDICTMENT

The presentation of the case was made by Attorney-General Homer Cummings, and by Assistant Attorney-General Thurman Arnold in charge of anti-trust activities. The Department began its investigations on August first,

and opened its case before the Grand Jury on October 17th. The indictment was announced on December 20th, and was printed in the New York Times, filling a page.

The indictment uses the word *conspiracy* repeatedly in describing the alleged acts of the defendants. It alleges that the defendants conspired for five purposes:

1. In restraint of the Group Health Association, Inc., in providing medical care and hospitalization for its members on a risk-sharing, prepayment basis.
2. In restraining the members of Group Association, Inc., from obtaining medical care for themselves from doctors engaged in group medical practice.
3. In restraining the doctors serving on the medical staff of the Group Health Association, Inc., in the pursuit of their calling.
4. In restraining doctors not on the medical staff of the Group Health Association, Inc., from practicing in the District of Columbia.
5. In restraining the Washington hospitals in the business of operating such hospitals.

THE BILL OF PARTICULARS

In support of the charge of a conspiracy by the members of the medical societies, the following findings are cited:

1. In the beginning early in 1937, methods

in restraint of practice were discussed in the District of Columbia Medical Society with the knowledge and advice of the American Medical Association.

2. On November 3, 1937, the Medical Society of the District of Columbia passed a resolution stating that it apparently has a means of hindering the successful operation of Group Health Association by preventing the patients of physicians in its employ from being received in local private hospitals. The A. M. A. approved this resolution.

The Medical Society of the District of Columbia issued a "White list" of approved organizations, groups, and individuals, omitting from it the Group Health Association, Inc., with the intent and purpose of instituting disciplinary action against any members of the local medical society who became members of the Staff of the Group Health Association, Inc. The Medical Society of the District of Columbia instituted disciplinary proceedings against the only two of its members who were on the Medical Staff of the Group Health Association. By reason of this disciplinary action one of the two doctors resigned from the Staff of the Group Health Association, and the other was expelled from the Medical Society. The defendants also brought similar disciplinary proceedings against a specialist on the alleged ground that he had consulted with the member who had been expelled.

The defendants also prevented doctors on the staff of the Group Health Association from treating their patients in the hospitals.

The indictment closes with the finding that the defendants have engaged in a conspiracy in restraint of "Said trade and commerce in and of the District of Columbia, contrary to the statute in such case made and provided; and against the peace and dignity of the United States of America."

(The statements regarding the bill of particulars were abstracted from the copy of the indictment that was printed in the New York Times of October 21, 1938.—The Editor.)

PRESIDENT CARRINGTON'S STATEMENT

On December 21, 1938, the New York Times and other daily newspapers printed the following comment by W. J. Carrington, M.D., President of The Medical Society of New Jersey:

Dr. William J. Carrington, President of The Medical Society of New Jersey, commenting today on the indictment of the American Medical Association on a charge of violating the Sherman anti-trust act, declared that "organized medicine is not opposed to group medical care".

"The fact is," Dr. Carrington said, "that there are 2,000 such groups in the United States which have the support and approval of organized medicine.

"The first three-cents-a-day hospital insurance plan in the country was started in New Jersey, and for years has had the active support of The Medical Society of New Jersey. The Washington plan did not receive the sanction of the District of Columbia Medical Society or the A. M. A. because its members were not permitted free choice of physicians and because a third party hired and 'sublet' physicians' services.

"Organized medicine has always believed that its right to discipline its own members was just as unimpeachable as the right of trade unions to discipline their members. Whether the indictment is sustained or not, it will bring the issue before the public. The American people themselves have the right to determine whether they want to preserve the present form of medicine and improve its distribution or replace it by some government controlled system."

The New York Herald Tribune of December 22, 1938, page 20, printed the following editorial:

THE DOCTORS ARE INDICTED

With his indictment of the American Medical Association and its eminent officers, together with its District of Columbia affiliates and several of the leading physicians of Washington, Mr. Thurman W. Arnold has fired the second gun of his campaign to regulate the vexed question of "group medicine" through the unlikely instrument of the anti-trust laws. The ordinary American entertains, we believe, a high respect for the medical profession as composed in general of men of exceptional unselfishness, competence and devotion. When he thinks of it, he probably admires its powerful official organization—represented by the American Medical Association and its local societies—for the probity with which it has maintained ethical and technical standards and policed the profession against quackery and venality. It will be difficult for Mr. Arnold to convince the public that American physicians are a greedy crew and their organization a selfish monopoly primarily interested in the ruthless suppression of competition.

On the other hand, the ordinary American is coming to regard the leadership of the Medical Association as inclined to err rather heavily on the conservative side in facing the real problems underlying the economics of medical care in the contemporary world. He is being led to doubt whether that leadership is fully representative of the most alert thought among physicians themselves on this social and economic side of medical care; and if the facts should tend to sustain Mr. Arnold's allegations of a fairly ruthless suppression, in the District of Columbia, of a possibly hopeful experiment in voluntary group medicine, it would be difficult for the American Medical Association to convince the public that its action was either wise or allowable.

The anti-trust laws seem to us a most unsatis-

factory instrument wherewith to raise this issue. If, as he hopes, Mr. Arnold gets a consent decree regulating the Washington situation alone, it will leave the Department of Justice with a kind of discretionary power over medicine it is hardly competent to exercise. If the case is fought through the courts, as the medical association promises that it will be, it must end either in a victory for them, which would leave everything as before, or a defeat which might very gravely jeopardize their invaluable function of generally policing the profession. Now, however, that the battle has been joined, it will have to be fought out, and perhaps the air will be somewhat clearer when it is over.

Editorial opinion of the Evening Public Ledger, Philadelphia, Pa., December 22, 1938:

Issues of far-reaching importance to the people of the United States are involved in the indictment by a District of Columbia Grand Jury, of the American Medical Association * * * on the charge of participating in an unlawful combination and conspiracy in restraint of trade. It is an extraordinary charge, and in many ways unprecedented. It calls the doctors to account under the Sherman Anti-Trust Act, alleging that they intend to make and maintain a monopoly of medical service. The case, of course, will be bitterly fought to the final decision in the Supreme Court of the United States.

But, on the other side, is the plain intent of the Federal Government to establish the principle of group health insurance on its own terms. * * * Voluntary enrollment of individuals in providing medical care is the forerunner of compulsory health insurance under Federal control, probably paid for, in part, with public funds.

The complaint of the doctors against Group Health Insurance, Inc., was two-fold:

1. It denied the right of the patient to choose his own physician, requiring him to call on a doctor associated with the organization.

2. A "third party" intervened between patient and physician, hiring the doctor's skill and services, and selling them to the subscriber.

In vigorous terms the men of organized medicine have denounced these characteristics of the plan. They consider them dangerous to the public health, mainly because of the possibility that incompetent practitioners may attach themselves to this type of organization for the sake of the fixed income it offers. They regard them, too, as destructive of the rights and responsibilities of the profession and ultimately of all private medical practice.

The doctors, therefore, must now defend another point of principle. Dr. William J. Carrington, President of The Medical Society of New Jersey, points out that "organized medicine has always believed that its right to discipline its own members was just as unimpeachable as the right of trades unions to discipline theirs". The principle involved is fundamental, for the code of professional conduct and ethics has bound the men of medicine for centuries, and is effective because there has been power to enforce it. Refusing sanction and approval to the Group Health Association, organized medicine had no choice but to put pressure on physicians who defied its disapproval. This is the case before the court, but a larger issue is before the country. It is not the question whether group health insurance is right or wrong. It is already an established fact. What must now be determined is whether it shall be planned, organized, and controlled by the medical profession, or by the private commercial enterprise, and eventually by Government.

THE HEALTH AND WELFARE COMMISSION OF NEW YORK STATE

The State of New York has approached the problem of health and welfare by legislative enactment, in contrast with the action in New Jersey in which Governor Moore has appointed an informal commission to study health conditions, and to suggest methods of extending the scope of medical services. (Jour., Dec., 1938, p. 751.)

THE NEW YORK COMMISSION

Section one of the New York Law that was passed early in 1938 declares the policy of the State to be:

1. Health of the inhabitants is a matter of State concern.
2. Adequate medical care is an essential element of public health.
3. Efforts of the medical profession should be supplemented by the State and local governments.

4. The problem of economic need, and that of providing adequate medical care are not identical, and may require different approaches.

5. A long-range State health program directed toward all groups of the population should be formulated and carried out.

Section two of the law establishes a commission of thirteen members, one of whom shall be a physician. Only one physician was appointed—Dr. Thomas P. Farmer, Syracuse, Chairman of the Committee on Public Health of the Medical Society of the State of New York.

SCOPE OF STUDY

The scope of the Commission's study is indicated in section three of the law, as follows:

The duty of the commission is—To recommend to the Legislature a long-range State health program; to investigate, study, and

analyze ways and means for improving and maintaining the health of the people, including the following:

- a. Increasing preventive efforts.
- b. Funds for adequate medical care for those of low incomes.
- c. Funds for the support of medical education, and for studies of procedures for raising the standard of medical practice.
- d. Funds for medical research.
- e. Funds for hospitals for people of low incomes, and for laboratory, diagnostic, and consultative services.
- f. Funds for utilizing private institutions in the objectives of section e.
- g. Planning and executing the measures by persons expert in the work involved.
- h. Adequate administration and supervision of the health functions of the State government.

The Commission has held hearings in several cities of the State. Those in New York City were held in the Bar Association Building, 42 West 44th Street, with the following schedule of the groups to be heard:

December 13—

- 10:00 a. m.—Official government agencies.
2:30 p. m.—Medical and Dental Societies.

December 14—

- 10:00 a. m.—Public Health organizations and Insurance Companies.
2:30 p. m.—Citizen groups.

December 15—

- 10:00 a. m.—Philanthropic groups.
2:30 p. m.—Labor organizations and fraternal orders.

December 16—

- 10:00 a. m.—Representatives of industry, funds, and foundations.
2:30 p. m.—Allied professional organizations.

The following sheet of mimeographed questions was handed to each person who attended a session, with an invitation to answer them:

1. The relief population of this State are receiving some kind of medical care. Assuming that the problems of medical care will exist for relief recipients over a number of years, what suggestions would you offer for a long-range health program for this group of the population?

2. Perhaps the most important problem of medical care presented is that concerning the low-income group of the population of this State. There has been considerable discussion as to whether or not the application of the principles of insurance to the various aspects of this problem might lead to a solution. At the present time there are various voluntary insurance plans in effect dealing with hospital service insurance. These meet with the approval of the State and national medical and hospital associations. In addition, the House of Delegates of the American Medical Association at its special session on September 16th, 1938, adopted the following statement: "In addition to insurance for hospitalization your committee believes it is practicable to develop cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness." (A. M. A. Journal.) What is your opinion as to the efficacy of some form of sickness insurance as a remedy for this situation?

3. Public health activities, including public health nursing, communicable disease control and school examinations, have been a part of the functions of State and local government for many years. Do you feel that present public medical and health facilities meet the need for care of persons unable to provide such care for themselves? If not, specify what needs are not being met and what methods should be used to extend these programs or facilities and under what official auspices.

4. The Interdepartmental Committee presented an extensive public health and medical care program at the National Health Conference held last July in Washington. This program includes both preventive and curative health measures. From your experience and knowledge of the problems of health, would you agree with the statement "that the present efforts of the medical profession in providing medical care should be supplemented by state and local governments"?

5. What functions do you think private health organizations should perform in public health programs of the State?

Some of the daily newspapers of New York City gave considerable space to the hearings, but no indication of the attitude of the Commission is available.

MEMORIALS TO JAMES J. McGUIRE

1. BY THE TRUSTEES OF THE MEDICAL SOCIETY OF NEW JERSEY



DR. JAMES J. McGUIRE

To Dr. James J. McGuire, physician and Secretary of the State Board of Medical Examiners, the members of The Medical Society of New Jersey express this tribute of love and affection:

Within the garden of your soul there bloomed
Choice flowers whose fruitage, beautiful and
sweet,

Was service to your fellow-men and God.
Endowed with healing gifts divine and rare,
You gave your own rich life that we, your
friends,

Might share your heavenly passion and your
power.

Adopted by the Board of Trustees of The
Medical Society of New Jersey, December 4,
1938.

HARRY R. NORTH,
THOMAS K. LEWIS,
WILLIAM F. COSTELLO,
Committee.

2. BY THE BOARD OF MEDICAL EXAMINERS

Whereas, An all-wise Providence has seen fit to remove from our midst, our beloved and esteemed colleague and friend, Dr. James J. McGuire, who for many years lived a life of unselfish service and wisdom in the practice of his profession; and

Whereas, Those qualities which distinguished him as a Physician applied also to his personal life, and endeared him to all who knew him; and

Whereas, His passing will be felt deeply by the entire membership of this Board because of the respect for his judgment and intense,

unswerving desire to serve the entire professional body without thought of self, but with high principles and courage;

Therefore, be it resolved, That in token of our deep and sincere appreciation of his services these resolutions be spread on the minutes of this Board, and that an engrossed copy be forwarded to his family, to the members of which we desire to express our warmest sympathy.

Adopted November 16, 1938.

E. S. HALLINGER, *Secretary*.

DR. HARRY S. WILLARD

Dr. Harry S. Willard, a practicing physician of Paterson for forty years, died on December 11th, 1938, in his home in Ridgewood. He was born in Jersey City on October 21, 1876, but had lived in Ridgewood since 1887. He graduated from the New York Medical College in 1896, and two years later from the New York Ophthalmic College, and spent his internship in Flower Hospital. He then opened an office in Paterson as an ophthalmologist and confined his work to that specialty.

Dr. Willard was on the staff of the Paterson General Hospital, and was one of the organizers of the Paterson Eye and Ear Infirmary, serving on

its staff until the time of his death. He was also on the consulting staff of Bergen Pines Hospital in Bergen County, the Good Samaritan Hospital of Suffern, N. Y., and the Tuxedo Park Hospital. He was an active member and Past President of the Passaic County Medical Society.

Dr. Willard was public-spirited and was a member of the Board of Trustees of the Citizens' First National Bank of Ridgewood. He was also a leading member of the Board of Education of Ridgewood, and had the honor of having one of its schools named after him. He took a deep interest in the welfare and recreation of the students, and organ-

ized a rifle and shooting club for them, and offered prizes in their competitions. He was also a promotor of Boy Scout activities, and was active in the Masonic fraternity, and the Elks Lodge.

The Passaic County Medical Society passed the following resolution of respect and appreciation of his life and services:

"Dr. Willard was a skillful adviser and sympathetic friend to his patients, a careful and competent ophthalmologist and consultant to his confreres; and a loyal and useful member to the Medical Society. He gave freely of his time and energy, his scientific knowledge, and his natural executive ability."

FRANK C. ARD

Dr. Frank C. Ard died on August 23rd of heart disease at the age of seventy-four. Dr. Ard was the first eye, ear, nose and throat specialist to come to the Plainfield area, and for many years was the consultant in that specialty to the Muhlenberg Hospital.

Dr. Ard was prominent in extra-medical activities also and was a Past President of the State Trust Bank. He was an honorary member of the Union County Medical Society, although in recent years he has lived in Westfield, Chautauqua County, New York, where he died.

STEPHEN T. QUINN

Stephen T. Quinn, of Elizabeth, died on September 18th at the age of seventy-one of bronchopneumonia, thus bringing to a sudden close a long and varied medical life.

Dr. Quinn was Chief of the Surgical Staff of St.

Elizabeth Hospital for many years. Because of his war-time work, he had risen to the rank of Lieutenant Colonel in the Reserves.

He was a Past President of the Union County Medical Society, and the State Surgical Society.

DECEASED PHYSICIANS—NEW JERSEY

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Alexander Macalister	76	Nov. 22	Camden	Same	Cancer of stomach.
William A. Miller	84	Nov. 30	Hohokus	Same	Cerebral apoplexy.
Charles S. Neves	51	Nov. 4	Montclair	Same	Coronary occlusion.
Stephen T. Quinn	71	Sep. 1	Waterville, Me.	Elizabeth	Heart block.
Frederick W. Steinbock	72	Nov. 7	Long Branch	Avon-by-Sea	Uremia

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE
STATE BIOLOGICALS SINCE JULY 1, 1938

DIPHTHERIA TOXOID					SMALLPOX VACCINE				
County	Total to Nov. 30	Month of Dec.	Total to Dec. 31	Average per Month	County	Total to Nov. 30	Month of Dec.	Total to Dec. 31	Average per Month
Atlantic	385	102	487	81.1	Atlantic	249	146	395	65.8
Bergen	1621	139	1760	293.3	Bergen	1323	53	1376	229.3
Burlington	50	31	81	13.5	Burlington	237	5	242	40.3
Camden	650	8	658	109.6	Camden	2124	4	2128	354.6
Cape May	346	7	353	58.8	Cape May	326	6	332	55.3
Cumberland	60	5	65	10.8	Cumberland	180	1	181	30.1
Essex	5223	1285	6508	1084.6	Essex	2845	385	3230	538.3
Gloucester	42	8	50	8.3	Gloucester	280	18	298	49.6
Hudson	1899	59	1958	326.3	Hudson	2179	307	2486	414.3
Hunterdon	4	0	4	.6	Hunterdon	17	0	17	2.8
Mercer	763	583	1346	224.3	Mercer	799	55	854	142.3
Middlesex	861	5	866	144.3	Middlesex	1597	5	1602	267.
Monmouth	209	6	215	35.8	Monmouth	134	857	991	165.1
Morris	231	44	275	45.8	Morris	600	28	628	104.6
Ocean	3	64	67	11.1	Ocean	45	0	45	7.5
Passaic	1314	229	1543	257.8	Passaic	1116	139	1255	209.1
Salem	46	16	62	10.3	Salem	328	7	335	55.8
Somerset	81	3	84	16.	Somerset	1107	3	1110	185.
Sussex	0	0	0	0	Sussex	0	0	0	0
Union	522	345	867	144.5	Union	689	86	775	129.1
Warren	8	92	100	16.6	Warren	147	1	148	24.8
Totals	14318	3031	17349	2891.5	Totals	16322	2106	18428	3071.3

CONTACTS AND COMMENTS

Mr.
and
Mrs.
—
It Can't
Be
Helped



From the New York Herald Tribune, Nov. 3, 1938.

A sneeze has social as well as health implications.

OBJECTIVES AND DUTIES

By JOHN BLANE, M.D.

Abstract from the President's Address before the Ninety-sixth Annual Meeting of The Medical Society of New Jersey in New Brunswick, N. J., January 29, 1862.

Dr. John Blane, elected President in 1861, was one of the most prominent and active members of The Medical Society of New Jersey, and took a prominent part in medical legislation. He strongly advocated a high standard of requirements of medical education and protested against the low standards of some of the medical colleges whose graduates by the law of 1854 were admitted to practice without further examination. He and Dr. Joseph Parrish, President in 1891, advocated that a *board of medical examiners* be established by law to examine all candidates for licensure, including the graduates of medical schools, thus anticipating the law of 1890 by which such a board was finally established.

In his address in 1862, eight years after the enactment of the law permitting graduates of all medical colleges to practice medicine, Dr. Blane made an eloquent plea to the *individual members* of the State Society to uphold the high standards of the practice of medicine, regardless of what the law permitted and condoned.

Self-preservation being a first law of nature, shall not our Society declare what shall be the necessary qualifications for membership? Shall they not, as they have been first in the institution of medical associations, first to separate the licensing from the teaching power, be first to institute a standard independent law, for the admission of its members? The American Medical Association is laboring to erect a standard and regulations for the profession from among whom the members of the Association shall be chosen. Shall we not keep in advance of them and erect that standard among us at once?

If The Medical Society of New Jersey is

considered by the Legislature as worth no more to the citizens of the State than the privileges granted in their charter, is it worth preserving? Would it not be prudent, and matter of sound policy, to surrender it?

Is it not time the co-partnership should terminate? Perhaps it may be thought best by members of the Society to ask the Legislature for more favors, and if so, this would certainly be a favorable time for that purpose. The State is now, notwithstanding the drain made upon it by the war, well filled with practitioners of all classes. But before asking, let us pause and consider whether it is for the advantage of the Society, and for the good of the citizens of

the State, to do so. Science and philosophy, like true religion, flourish most when not meddled with and trammelled by law.

In the words of Dr. Charles A. Pope, late President of the American Medical Association:

Ours is a popular government, and the people are disposed to allow the largest freedom in everything pertaining to medicine, medical schools, and physicians. Laws passed against quackery one year are revoked the next. Our country is the paradise of quacks. All good things have their attendant evils; and this unbridled liberty is one of the evils of a popular government. May we not hope, however, that even this evil may disappear as general education and the cultivation of the masses advance? At any rate, the people are not yet disposed to put down the quacks, nor to require too high a degree of qualification for those of the regular profession. After all, laws can make only mediocre physicians. They can require the candidates to know only so much; to be qualified to a certain degree; and this degree will always be far lower than that to which the true lovers of knowledge would attain without any legislation on the subject. The greater lights of the profession cannot be manufactured by any process of legislative enactment. Thirst for knowledge, self-love, philanthropy, burning ambition—these make the great physician and surgeon. These have made all the worthies of the past—not legislation. Legislation can not drive the drone to the grand heights of professional eminence. When those heights are reached, it will be seen that the successful aspirant has been stimulated by a stronger power. To him the laurel-blossoms of renown and the life-giving mission of his art are dearer and more attractive than was the mystic bough of the sibyl to the eager Aeneas, or than the golden apples guarded by the sleepless dragons to the Hesperian daughters.

Much has been effected by association; yet all the improvements were the labors and discoveries of individuals often living in retire-

ment, and made known by men valued most for their individual worth; and it is to this source that, at this time, we are more particularly to look for the advancement of our profession. Association, except for the express purpose of inquiry and disseminating the knowledge acquired by individuals, will avail nothing.

Association, without individual exertion, never has and never will elevate any profession or body of men as such; it is by the elevation of the different members of a profession that the whole is elevated and benefited. The beginnings must be with the individual member. And here each and every one should conduct himself as though the fair standing of the profession depended solely on himself; as though by his exertions everything was to be obtained; as though the eyes of the whole profession and the rest of mankind were upon him and expected it of him.

Membership in an association has but a small share in conferring honor on a member otherwise unworthy. Instead of elevating either him or the association or profession to which he belongs, it lessens both in the eyes of a discriminating public.

Let every member of our society resolve himself into a committee on the preliminary education of students entering their office. Let him examine well not only the acquirements of the applicants, but also their habits as to study, industry, determination, and fitness for professional life; and in a short time the effects will be seen, not only on the profession, but on the community at large, in the greater amount of confidence by them bestowed upon it.

225-65-6
Medical history is repeating itself over and over. During the two decades, 1845-1865, medical legislation was a burning subject of discussion and action by The Medical Society of New Jersey, yet all its efforts did not prevent the passage of a law permitting graduates of low-grade medical schools from being admitted to practice medicine,—just as in 1938, the Legislature not only refused to pass amendments

to the medical practice act proposed by the State Society, but also passed a law requiring the Board of Medical Examiners to admit to the examinations the graduates of any *legally incorporated* medical school regardless of its standing.

Read the statement of the Board of Medical Examiners on page 45.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

JANUARY, 1939

3 Camden	12 Passaic
3 Hudson	13 Atlantic
6 Salem	17 Warren
10 Bergen	18 Middlesex
11 Mercer	19 Gloucester
11 Ocean	19 Morris
11 Union	24 Hunterdon
12 Burlington	25 Monmouth
12 Essex	

FEBRUARY, 1939

7 Camden	10 Atlantic
7 Hudson	10 Salem
8 Mercer	14 Bergen
8 Ocean	14 Cumberland
9 Burlington	15 Middlesex
9 Essex	16 Gloucester
9 Passaic	16 Morris
9 Somerset	22 Monmouth

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular monthly meeting of the *Bergen County Medical Society* was held in the auditorium of the Holy Name Hospital, Teaneck, N. J., on Tuesday evening, December 13, 1938. The meeting was called to order by the President, Dr. Chester A. King, at 9 p. m.

NEW MEMBERS

Dr. W. C. Craig, Ridgewood, was elected to regular membership, and Drs. E. A. Andrick, Hohokus; R. H. Ringewald, Leonia; R. F. Gueringer, Cliffside Park; and J. D. Levy, Hackensack, were elected junior members.

Four applications for regular membership, and one for junior, were received.

MEDICAL-DENTAL SERVICE BUREAU

Dr. Tether gave a brief report on the Medical-Dental Bureau of Bergen and Passaic Counties, and referred to the letter in the December Bulletin (p. 15) from Mr. Kinne, the Executive Director of the Bureau, calling attention to the use of the Bureau as an agency for collecting overdue accounts; while its object is that, before a bill is incurred, as for an operation, the Bureau should assist the patient to budget his resources so as to pay the bill within a certain number of months.

LEGISLATION

Dr. Samuel Alexander reported on the discussion which came up at the last Welfare Committee meeting of the State Society concerning the re-introduction of Assembly Bill 511 in the coming session of the Legislature in Trenton. He stated that the main concern of the Welfare Committee was the actual sentiment of the members-at-large throughout the State. Dr. Alexander outlined the five salient features of the bill, which were briefly:

1. The necessity of citizenship before granting a license to practice.
2. Chiropractors will not be licensed unless they present the same requirements as an M.D.

3. Improvements in the reasons for revocation of a license to practice.

4. More definite penalties set up for violations of the Medical Practice Act.

5. Prohibition of every phase of corporate practice except that which is controlled by the State Compensation Act, and which thus affects the relation between employer and employee.

After some discussion a motion was made and seconded granting endorsement of the Bergen County Medical Society to the plan for re-introducing this bill; and further, urging the State Welfare Committee to place the bill before the legislature as soon as possible. This motion was unanimously carried, thus clearly showing the sentiment in Bergen County.

SCIENTIFIC

Dr. Byron Stookey, Director of Neurological Surgery, Neurological Institute, New York City, was introduced by Dr. Walter Farr, Chairman of the Scientific Committee.

Dr. Stookey talked to us concerning the recent developments in the diagnosis and treatment of low back pain and sciatica, with special reference to herniations of the nucleus pulposus.

He reviewed the problem of low back pain, and the various entities into which it has now been divided. This led to a discussion of corda equina tumors and dislocations of the intervertebral discs, which latter are now known to be herniations of the nucleus pulposus. He discussed the great difficulty in diagnosis because of the paucity of the objective neurological signs and symptoms. He suggested the introduction of air, particularly oxygen, in the lower spinal canal as the best aid in diagnosis. Lipiodol is, of course, a great help; but it has its definite dangers, and is an irritant.

The latter part of his talk, which we all enjoyed tremendously, was given over to the showing of slides of diagnostic interest.

After some discussion of Dr. Stookey's talk, the meeting adjourned.

BURLINGTON COUNTY

Carlton P. Hogan, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on December 9, 1937, President Dr. Frederick D. Fahrenbruch presiding.

SCIENTIFIC

Dr. Parry M. Scott, Chairman of the Committee on Program, introduced Dr. Lewis K. Ferguson, Associate Professor of Surgery, University of Pennsylvania, who presented an excellent paper on "Anorectal Diseases", illustrating his talk with lantern slides.

The Executive Committee recommends:

1. Having our county society officers assume offices at the close of the Annual Meeting of the State Society.

2. Having a President-Elect elected at the annual meeting of the county society so that he could become more familiar with his duties as President the following year.

These proposals were referred to Committee on Constitution and By-Laws.

VENEREAL DISEASE CONTROL

Dr. Robert E. Imhoff reported that the State Department of Health could augment local efforts to control syphilis with aid of Social Security funds, to open seven stations in Burlington County. Two at the present time are now functioning, one at the Burlington County Hospital, Mt. Holly; the other at Zurbrugg Hospital, Riverside.

The society went on record as approving the venereal disease plan of the State Department of Health to set up local treatment centers in Burlington County.

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on January 13, 1938. President Dr. Frederick D. Fahrenbruch called the meeting to order at 9:30 p. m.

SCIENTIFIC

President Fahrenbruch turned the meeting over to Dr. Parry M. Scott, Chairman of the Committee on Program and Arrangements. Dr. Scott introduced the speaker of the evening, Dr. Martin Biederman, of New York City, who gave a most interesting and instructive paper on "The Injection Treatment of Hernia", illustrating his remarks with motion pictures.

VENEREAL CLINIC

It was announced that the Venereal Clinic at the Burlington County Hospital had been placed on the approved list, but no funds were available to pay Dr. Viteri, pathologist of the hospital, since there is no assurance of local funds being supplied to match the State funds.

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on February 10, 1938. President Dr. Frederick D. Fahrenbruch called the meeting to order at 9:30 p. m.

SCIENTIFIC

Dr. S. Emlen Stokes introduced the speaker of the evening, Dr. John H. Stokes, international authority on syphilis, who read a paper on "Venereal Disease Control".

COUNTY PSYCHIATRIST

The society duly approved of a Burlington County psychiatrist to aid in dealing with problems of juvenile delinquency, and agreed to aid the Board of Chosen Freeholders by giving advice in the selection of the psychiatrist.

W. P. A. NURSING

Dr. Joseph M. Kuder, Chairman of the Burlington County Medical Society Committee on Public Relations, gave a report on the W. P. A. Nursing Project for Burlington County.

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on March 10, 1938. The meeting was called to order by President Dr. Frederick D. Fahrenbruch at 9:30 p. m.

SCIENTIFIC

Dr. Parry M. Scott, Chairman of the Committee on Program, presented seven members of the society, who gave case reports as follows:

"Management of Case of Premature Separation of the Placenta"—Howard C. Curtis

"Case of Long Standing Poliomyelitis"—E. Vernon Davis

"Case of Juvenile Diabetes in Coma"—Paul R. Sparks

"Case of Congenital Absence of the Uterus"—Hammell P. Shipp

"Case of Pneumonia with Serum Treatment"—Dean H. LeFavor

"Results from Injection Treatment of Hemorrhoids"—Parry M. Scott

"Résumé of Venereal Disease Clinic at Burlington County Hospital"—Louis E. Viteri

All of these case reports proved to be extremely interesting and instructive. It is the consensus of opinion that at least one meeting a year should be devoted to papers presented by our own men.

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club, April 14, 1938. President Dr. Frederick D. Fahrenbruch called the meeting to order at 9:30 p. m.

SCIENTIFIC

Dr. Scott introduced Dr. Eric M. Matsner, Executive Secretary of the National Medical Council on Birth Control, who gave a very interesting paper on "Contraception", illustrating his talk with lantern slides.

BOARD OF MEDICAL EXAMINERS

Due to the death of Dr. H. H. Satchwell leaving a vacancy in the New Jersey State Board of Medi-

cal Examiners, Burlington County not having been represented on the Board for twenty years, the Executive Committee recommends that three men, Dr. T. J. Summey, Dr. E. W. Rodman and Dr. F. D. Fahrenbruch, be recommended to the Board of Trustees as candidates to fill the vacancy.

VENEREAL DISEASE CONTROL

Dr. Robert E. Imhoff, reporting for the Committee on Venereal Disease Control, presented five applications for appointment to the venereal disease clinics.

Dr. Paul R. Sparks was elected for the Venereal Disease Clinic in Burlington, Dr. Mendenhall for Bordentown, and Dr. Love for Moorestown.

The regular meeting of the *Burlington County Medical Society* was held at the Riverton Country Club, Riverton, N. J., on May 12, 1938. The meeting was called to order at 10 p. m. by President Dr. Frederick D. Fahrenbruch.

President Fahrenbruch welcomed our guests, the members of the Woman's Auxiliary, and Drs. Diverty, Wood, Crain and Greene. Mrs. Carlton P. Hogan, President of the Woman's Auxiliary, responded with a few words of thanks.

EXECUTIVE COMMITTEE

The Executive Committee recommends:

1. That the matter of a survey of medical service in Burlington County be referred to the Committee on Public Relations, Dr. Joseph M. Kuder, Chairman.

2. That the matter of referring inoperable cancer patients to the new Welfare Home to be built in Burlington County be referred to the Public Health Committee, Dr. H. P. Shipp, Chairman.

These recommendations were adopted.

SYPHILIS CAMPAIGN

The plan of ordinary disease control of the New Jersey Society of Clinical Pathologists for participation in the campaign against syphilis was adopted.

ENTERTAINMENT

Dr. Parry M. Scott, Chairman of the Entertainment Committee, introduced the entertainers of the evening. At the conclusion of the entertainment, a buffet supper was served and enjoyed by all.

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on September 8, 1938. President Dr. Frederick D. Fahrenbruch called the meeting to order at 9:20 p. m.

PRESIDENT'S CABINET

President Fahrenbruch introduced the speaker of the evening, Dr. Watson B. Morris, First Vice-President of The Medical Society of New Jersey. Dr. Morris spoke on "The Objective and Administrative Policies of The Medical Society of New Jersey", outlining President Carrington's program for the coming year.

CANCER CARE

The Secretary, Dr. E. W. Rodman, read a resolution adopted by the Board of Chosen Freeholders at a meeting held on May 27, 1938, recommending that a State institution be established for the care, support and responsibility of indigent and incurable cancer patients.

BABY CLINICS

Dr. H. B. Mark, of Riverside, was elected to care for the Baby Clinic of Delanco, and Dr. Freeman W. Metzger was appointed for the Baby Clinic of Riverside.

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on October 13, 1938. The meeting was called to order by Vice-President Dr. C. A. Munro at 9:20 p. m.

SCIENTIFIC

Dr. Parry M. Scott, Chairman of the Committee on Program, introduced the speaker of the evening, Dr. E. J. Beardsley, Clinical Professor of Medicine at Jefferson Medical College, who presented an interesting paper on "Men of Fifty".

CONSTITUTION AND BY-LAWS

Dr. Mulford, reporting for the Committee on Constitution and By-Laws, presented amendments for their first reading.

ENDORSEMENT

Dr. Elias J. Marsh was endorsed by the Medical Society for nomination as Second Vice-President of the Medical Society of the State of New Jersey at the 173rd Annual Meeting.

Dr. Ephraim R. Mulford reported on the special session of the A. M. A. delegates in Chicago and stressed the importance of having each member of the society read the report as published in full in the Journal of the A. M. A. A discussion of economic problems facing medical practice followed. It was decided by our Medical Society to postpone the Clinical Program and to devote the following meeting to the program on Medical Economics.

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on November 10, 1938. President Fahrenbruch called the meeting to order at 9:30 p. m.

SCIENTIFIC

Dr. Parry M. Scott introduced the speaker of the evening, Dr. Edward Bortz, of Philadelphia, who spoke on "Serum Treatment of Pneumonia", illustrating his remarks with lantern slides.

NEW MEMBER

Dr. James Q. Atkinson was elected a member of the society.

The Executive Committee report was as follows: The Executive Committee recommends that the communication from Dr. LeRoy A. Wilkes in reference to compiling a list of competent speakers on medical subjects from which the county societies may select speakers of interest and ability be referred to the Committee on Public Relations.

The recommendations of Executive Committee were duly adopted.

Chairman of the Committee on Constitution and By-Laws and the Secretary presented the amendments to the Constitution and By-Laws for second reading.

It was duly decided to have present officers and committees continue with their duties until May, and that the Treasurer be empowered to send out bills for dues at the present rate of \$25.00 per year.

PUBLIC RELATIONS COMMITTEE

President Fahrenbruch appointed a new Committee on Public Relations to serve until May with Dr. J. Howard Hornberger, Chairman; Dr. Hammell P. Shipps, and Dr. Freeman W. Metzger as the new committee.

Dr. James Q. Atkinson, appointed to fill the vacancy on the Public Health Committee, to the division on Mental Hygiene, to succeed Dr. Ralph G. Gladen, who has resigned and moved from the county.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The *Cumberland County Medical Society* held its December meeting at the Hotel Cumberland Tuesday afternoon, with Dr. Dare Woodruff the president, presiding. There was a large attendance of members of the society and from adjoining counties.

LEGISLATIVE

Dr. M. F. Sewall, society member of the welfare committee of the State Medical Society, gave a lengthy report of Medical bill A 511 that will be presented to the State Legislature for passage as a law, substituting for the present Medical Practice Act. The proposed bill was unanimously approved.

CANCER CONTROL

A cancer control committee was appointed by President Woodruff composed of Dr. J. Franklin Reeves, chairman; Dr. Charles Sharp and Dr. F. M. Ramsay. The duty of this committee is to provide better local facilities, concentrated in one hospital, for the latest and most efficient treatment of cancer.

NEW MEMBER

Dr. A. F. Magolda, of Vineland, was elected a member of the society.

SCIENTIFIC

The guest speaker was Dr. C. D. Head, of the United States Public Health Service. His subject was "Pneumonia", and was illustrated by motion pictures. Pneumonia occupies the third place as cause of death, the speaker said, cancer and heart exceeding it. There were 24 deaths in Cumberland County last year.

The speaker gave an extensive description of the treatment of pneumonia by sera, illustrating the relative mortality of the various types of germs. He showed the effect of the serum treatment on these types.

ESSEX COUNTY

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, December 15, 1938, at the Academy, 91 Lincoln Park, South, Newark, and was called to order by President Henry C. Barkhorn at nine p. m.

The tellers of the election, Drs. Raymond J. Mullin and Paul E. Menk, reported that all the ballots were in the affirmative and the president declared that the candidates were elected to Fellowship. Thirty-five Fellows and seven Junior Fellows were accepted.

Thirty-five candidates were elected Fellows, as follows:

John Arena, M.D., North Bergen
Frederick W. Becker, M.D., Newark
Adalberto Barroso-Bernier, M.D., Englewood
Walter A. Bodenweiser, D.D.S., Arlington
Selig L. Brauer, M.D., Jersey City
J. Howard Cooper, M.D., East Millstone
Judson G. Cottrell, M.D., Perth Amboy
Anthony Z. Domine, M.D., Emerson
Frank L. Foster, M.D., Cranford
Joseph T. Gialanella, D.D.S., Newark
David Goldberg, M.D., Westwood
Herman Gordon, D.D.S., Harrison
Carlton E. Hooper, D.D.S., Newark
J. E. L. Imbleau, M.D., Union
N. Johnson, D.D.S., Jersey City
John F. Judge, M.D., Newark
William Klein, M.D., New Brunswick
Arthur M. Kraut, M.D., Jersey City
C. H. Larrabee, M.D., Summit
Mortimer H. Linden, M.D., Jersey City
Joseph A. Mancari, D.D.S. Hoboken
Herbert E. McLean, M.D., Jersey City
Robert R. McLean, D.D.S., Jersey City
Maurice R. Olinger, D.D.S., Hoboken
Vincent J. Padula, D.D.S., Newark
Charles M. Peters, D.D.S., M.D., Jersey City
George W. Phelan, D.D.S., Weehawken
Nathan N. Rasnick, D.D.S., Newark
Aloysius P. Rieman, M.D., Jersey City
Grace M. Robertson, M.D., Plainfield
Abraham S. Schulman, M.D., Union City
J. Dewey Schwartz, D.D.S., Jersey City
Harrison V. Scudder, D.D.S., Jersey City
Juan A. Villegas, M.D., Fairview
Glen L. Yates, M.D., Belleville

Seven candidates were elected to Junior Fellowship, as follows:

Kasimier J. Bolanowski, M.D., Elizabeth
Bernard Lilien, D.D.S., Newark
Clifford B. Matthews, M.D., Newark
Joseph A. Mirabella, Jr., D.D.S., Newark
K. H. Movsesyan, D.D.S., West New York
Leo Schneider, M.D., Newark
Victor Tepper, M.D., Newark

Dr. Barkhorn introduced the guest speaker, Dr. Oswald S. Lowsley, Director of Urology, James Buchanan Brady Foundation, New York Hospital. The title of Dr. Lowsley's paper was, "Some New Operative Procedures in Urology." The operation described by Dr. Lowsley, were illustrated by lantern slides and motion pictures in their natural colors. Dr. Lowsley presented his subject in full and comprehensive detail.

The paper was discussed by Drs. O'Crowley, Menk and James.

PROGRAM FOR FEBRUARY, 1939

Council	Thursday, February 2
Medicine and Pediatrics	Tuesday, February 14
Stated Meeting, auspices	
Fye, Ear, Nose and Throat	Thursday, February 16
Surgery	Tuesday, February 28

Medicine and Pediatrics

Tuesday, February 14, 1939, 8.45 P. M.

"The Respiratory Defense Mechanism and Its Relation to Pulmonary Disease." (15 min.)

Irving Applebaum, M.D.

"Some Problems in Nephritis."

John P. Peters, M.D.,

Professor of Medicine, Yale University

Stated Meeting

Auspices Eye, Ear, Nose and Throat Section

Thursday, February 16, 1939, 8.45 P. M.

"Modern Viewpoints in the Diagnosis of Brain Tumors."

I. S. Wechsler, M.D., Professor of
Clinical Neurology, Columbia
University

Leo M. Davidoff, M.D., Ass't Pro-
fessor of Neurology, Columbia
University

Cornelius G. Dyke, M.D., Ass't Pro-
fessor of Radiology, Columbia
University

Discussion opened by: Wells P. Eagleton, M.D.

Surgery

Tuesday, February 28, 1939, 8.45 P. M.

"Surgery of the Stomach."

C. J. MacGuire, Jr., M.D., Ass't
Professor of Clinical Surgery,
Columbia University

All meetings are open to the profession and to medical students.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular meeting of the *Gloucester County Medical Society* was held on the evening of Thursday, December 15, in the Homestead Coffee Shop, Woodbury, with the President, Dr. William E. Crain, of Woodbury, presiding.

Delegates to the various county societies reported of their attendance at the meetings, and reports of the various committees, including the Public Relations Committee, the Public Health Committee, and the Committee on Post-Graduate Education, were presented.

X-RAY TESTING OF SCHOOL CHILDREN

The report of the Public Health Committee on the testing and x-raying of the school children and teachers of the county was approved. This work will proceed with the approval of the society through the agency of the Gloucester County Health Association, and will be carried on by funds made available through the sale of the Christmas seals. The primary objective this year will be to reach the pupils of high school age and the teachers.

SCIENTIFIC

The speaker of the evening was Dr. David Farley, of Philadelphia, who gave a very interesting talk on the "Diagnosis of Fever of Obscure Origin". He spoke at length of the various conditions in which fever was present and in which it was difficult to make a diagnosis of the underlying pathology.

LEGISLATION

Dr. Thomas K. Lewis, of Camden, the Second Vice-President of the State Society, was present and spoke on Assembly Bill 511. He explained the bill, and at the conclusion of his remarks the society went on record as being in favor of the State Society re-introducing the bill at the coming session of the legislature.

ROLL CALL

The following visitors were present: From Salem County, Dr. Church; from Cumberland County, Drs. Woodruff and Wilson; from Camden County, Dr. Lewis.

The following members were present: Drs. Crain, Diverty, Hughes, Rogers and Sherman, Woodbury; Drs. Ulmer and Gairdner, Gibbstown; Dr. Liven-good, Swedesboro; Drs. Hollinshed and Patterson, Westville; Drs. Burkett, Lummis, Knight and Barrows, Pitman; Drs. Wood, Sinexon, Serrati and Di-Marino, Paulsboro; Drs. Collins and Venturo, Glassboro; Drs. Weems, Zapf and Wentzell, Wenonah; Dr. Ruttenburg, Mantua; Dr. Gillis, Clayton; Dr. Fooder, Williamstown.

Dr. J. Harris Underwood was reported improved after an attack of streptococcal infection.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular monthly meeting of the *Hudson County Medical Society* was held on Tuesday, December 6th, 1938, at the Carteret Club, at 9:20 p. m.

REPORT OF SECRETARY

Secretary Brennock reported that the Public Relations Committee of The Medical Society of New Jersey has suggested a set-up with the New Jersey Bell Telephone Company, whereby they will place an "ad" in the classified section of the Telephone Directory showing that the members listed are members of the Hudson County Medical Society; and for this insertion "Members of the Hudson County Medical Society", the charge by the Telephone Company is twenty-five cents per man, which amounts to \$3.00 per year added to your individual telephone bill.

The advertisement, headed "Hudson County Medical Society", and pertaining to the qualifications of a physician and why he should be a member of his County Society, would be one-sixth of a page, and would cost the Society \$12.00 per month, or \$144.00 per year.

The Executive Committee of the County Society did not recommend its approval and suggested that it be discussed before an open meeting of the society.

After a full and lengthy discussion, Dr. H. Jaffe moved that we do not endorse this plan. Seconded. So ordered!

FEE FOR PRE-MARITAL EXAMINATION

At a meeting of the Welfare Committee of The Medical Society of New Jersey on Sunday, December 4th, held in Trenton, it was the consensus of opinion that a reasonable and fair charge for doing a pre-marital Wassermann was an average of \$3.00 per person.

After considerable discussion, Dr. P. D'Acerno moved that we endorse the average fee of \$3.00 per person, for a pre-marital Wassermann. Seconded by Dr. L. Lange, and carried.

PUBLICATION COMMITTEE

Dr. N. M. Alter, Chairman of the Publication Committee, outlined a plan to increase the contents of the Bulletin, to make it as useful as possible. He proposed to increase the advertising by hiring an advertising man to solicit advertisements.

SECOND DISTRICT MEETING

Dr. V. P. Butler, Councilor of the Second Judicial Councilor District, described the program of the district meeting to be held in Jersey City in the Carteret Club and St. Peter's College on the evening of December 15, and urged the members to attend it. (See page 44.)

MEDICAL ECONOMICS COMMITTEE

Dr. J. L. Evans reported, "This medical survey is a large job to complete. I noticed that there is a county in Indiana which assessed each member ten dollars and hired a firm of expert accountants to do this survey. I have almost done this work single-handed. The big job is to get out this industrial questionnaire. We depend mostly on the doctors to give us a lead on this. I wish, when you get the questionnaire, that you would answer this as accurately as possible."

MERCER COUNTY

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on the evening of December 14, with President Little presiding.

Dr. Norman M. Scott was introduced as the newly appointed Assistant to the Executive Officer of the State Society.

LEGISLATION

Dr. Samuel Alexander and Dr. Frederic J. Quigley described the Medical Practice Bill—A-511—which was defeated last year, and will be introduced again this year. The society voted its endorsement of the bill.

TUBERCULIN TESTING

Dr. Pessel reported progress in applying tuberculin tests to school children.

SPEAKERS' BUREAU

Dr. Watts reported for the Public Relations Committee and called special attention to the need for more coöperation on the part of members in signing up on the Speakers' Bureau.

MATERNAL WELFARE

Dr. Harman made a verbal report regarding present needs of the Maternal Welfare Committee.

NEW MEMBERS

Drs. Cunningham, Goldman and Shear, were elected to active membership; and Drs. Abrams, Colavita, Communi, Dodge, Hafetz, Harrop, James, Janoff, Johnson, Kohn, Koplin, Lynch, Minschwaner, Mountford, O'Neill, Sackin, Steel, Tenney, and Wilson were elected associate members.

ELECTION OF OFFICERS

The following officers, committee members and delegates were regularly elected:

President, Thomas J. Walsh
Vice-President, Elmer J. Elias
Treasurer, Harry R. North
Secretary-Reporter, A. D. Hutchinson

Member of State Nominating Committee, Harry R. North
Alternate of State Nominating Committee, D. Leo Haggerty
Executive Committee: R. J. Cottone, W. R. Peterson, W. C. Ivins
Member of Board of Censors (3 years), John T. Dimun

Delegates to State Society:	Alternates:
E. B. Beirsto	R. J. Cottone
D. L. Haggerty	L. A. Stein
John J. Haney	J. N. Zimskind
W. E. D'Arcy	E. J. Elias

NOMINATING COMMITTEE

A motion carried that a committee be appointed to draw an amendment to the By-Laws providing for the creation of a Nominating Committee.

GROWTH OF THE SOCIETY

Dr. North gave a very interesting résumé of the growth of the society, and stated that out of the seventy-eight members affiliated with the society when he took over the office of Treasurer about twenty years ago, there remain living today only thirty-nine,—exactly half.

MIDDLESEX COUNTY

Louis R. Panigrosso, M.D., Reporter

A regular meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, N. J., November 16, 1938, with Dr. J. V. Smith, President, presiding.

SCIENTIFIC

The speaker of the evening was Dr. Harry Gold, assistant Professor of Pharmacology, Cornell Medical College, whose subject was "Drug Therapy in Coronary Disease". The paper was widely discussed by the members.

PRESIDENT'S CABINET

Dr. Watson B. Morris gave a brief talk on the objectives and administrative policies of The Medical Society of New Jersey.

NEW MEMBERS

Dr. Alexander Carr, Metuchen, and Dr. Cyril Hutter, Woodbridge, were admitted to full membership.

Dr. Edward Hansen was reinstated as a member of the society.

The following applications to associate membership were approved: Dr. Norman Reitman, New Brunswick; Dr. J. Smith, South River; Dr. W. Gadek, Perth Amboy; and Dr. John Connors, Metuchen.

Dr. D. C. Isaac requested to be transferred to Essex County; and Dr. Robert B. Pinerman to Mercer County.

The meeting adjourned at 11 p. m.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

The regular monthly meeting of the *Executive Committee of the Monmouth County Medical Society* was held at the Monmouth Memorial Hospital, Long Branch, N. J., on Monday evening, November 14th, at nine o'clock. The meeting was called to order by the President, Dr. C. B. Blaisdell. Members of the committee present were: Drs. Blaisdell, Pregnall, Gosling, Kazmann, MacKenzie, Clark, Moffat, Matthews, Albright, and Featherston. Also present at the meeting were Drs. Leonard, Hausman, Nichols, Perrine, Wilkins, Hancock, Kanes, and Peiper.

SPEAKERS' LIST

A communication from LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, was read concerning the compilation of a list of competent speakers on various subjects, both medical and allied, from which county societies may select speakers of interest and ability. The matter was referred to the Public Relations Committee.

SECURING NEW MEMBERS

A list of the practicing physicians in Monmouth County who are not members of the County Medical Society was presented and discussed. A motion was made and passed that the thirty eligible physicians be invited to become members of the Monmouth County Medical Society.

HOSPITAL SERVICE PLAN

It was reported that our members have been slow to respond to the Hospital Service Plan of New Jersey (Jour., Nov., 1938, p. 702). We are informed that there have been some definite changes in the plan which will be advantageous to the doctor, and it was decided to ask their representative to again appear before our group for further explanation.

CONTRACTS FOR MEDICAL SERVICES

Dr. Leonard reported for the Board of Censors that no definite conclusion had been reached in regard to the various contracts held by some of our members. The members of the Board are withholding their report until such time as a satisfactory contract has been outlined by The Medical Society of New Jersey.

FEE SCHEDULE

Dr. Blaisdell reported that several members in the northeastern part of the county had complained in a general way that the minimum fee schedule was not maintained in that vicinity. Dr. Stanley Nichols moved that the prevailing fee schedule for office and house visits be again published in the monthly bulletin and members urged to abide by the rates unless unusual circumstances are involved. The motion was seconded and carried, and the minimum fee schedule is quoted herewith: House visits, \$3.00. Office visits, \$2.00.

The meeting was then adjourned.

PRESIDENT'S COMMUNICATION

The following is a communication from our President, Dr. C. B. Blaisdell:

Membership: Our fall program is now in full swing, and it is time for us to make a definite move to strengthen and increase our membership. This has been discussed at the Executive Committee meeting, and I shall form a committee to assist in this drive. Regardless of what the future holds for medicine, we shall be better able to strengthen and fully organize our position if we do not leave loose ends in our membership. Twenty-five or thirty eligible doctors practice in Monmouth County who are not enjoying our programs and our privileges. We, in turn, need them.

Organization: The objectives of framing our society's committees and their work after the pattern of the State Society's is beginning to show results. If nothing else significant is accomplished this year, at least the groundwork for future activities will have been laid. If you are on a committee, do not sit back and wait for the chairman to call you, but be reading and thinking all you can in the field of work in which your committee is interested.

Again, I suggest you read your Bulletins, your State Journal, and read what the "other fellow" says about doctors. Then begin plans to work with him, for we have it coming.

Allied Meetings: 1. The New Jersey Health and Sanitary Association, which meets November 18th and 19th at the Berkeley Carteret Hotel, has a Friday program in which every doctor should be not only *interested*, but also *concerned*. This organ-

ization has to do with broad considerations of the provisions for health, the prevention of disease, and the means of providing the State with both prevention and adequate treatment. Enough doctors do not belong to this organization, although we are represented. The membership is only two dollars, and at least ten per cent of our membership should join.

2. The New Jersey Welfare Council, composed of representatives of State agencies—medical, nursing, welfare, and social—meets in Asbury Park. We should cover this meeting and see what the trends are in New Jersey. If unable to get ourselves to some sections, it might not be amiss for our wives, as members of the Woman's Auxiliary, to attend. Dr. Nichols and I have each been asked to lead one of the seventeen discussion groups. Drop in and give us some support, particularly if you are a committee chairman.

School Physicians: Some new regulations have been passed by the State Board of Education concerning school health services. If you are a school physician, read particularly sections 64, 66, and 67. Summarized, these state that the medical inspector shall direct the activities of the school nurse and her professional duties, and compile and issue regulations governing professional technics, the continuation of inspections and tests, and the admission of treatment; that they shall omit inspection of teeth and gums in examining pupils who have been, or who will be, examined by a school dentist in the current school year; and that they may accept a record of a thorough physical examination made by a family physician or a physician working under a plan for the examination of pre-school children, if the plan and the records used in either type of examination have been approved by the State Board of Education. Specifically this refers to the form approved by our State Society.

Pneumonia: Do you know how to get free serum for our medically indigent cases, in, or out of, a hospital? Through your local Health Officer, and with the help of Fitkin Hospital, free typing can be secured. You can get all the details at this coming meeting, including a definition of "Medically indigent" versus "Indigent".

Tuberculosis: An even hundred cases of tuberculosis are to be studied thoroughly in the County of Monmouth from all angles, through the years to come. It is, and will be, an excellent example of the value of coöperation of doctors, health officers, nurses, and governing bodies. Incidentally, do you know how to perform and interpret a "Patch" test, and its value versus a "Mantoux" or "Von Pirquet"? Our T.B. Committee planned to tell and show us this last May at the Marlboro meeting. We hope it will be brought up again, and soon.

Syphilis: Regional Health Commissions, through a new law, affect our practice. Most of them, composed of men well known to us variously, look to us for authentic information as health experts. In syphilis they permit a pooling of funds to pay doctors working in clinics. It is understood, although not official, that Red Bank is considering leading the attack on syphilis with a \$1500 appropriation

for next year. Meanwhile, Asbury Park has not yet paid for the medical work in its heavily loaded clinics for this current year, despite the fact that it has a venereal disease problem not far from being the greatest in the county. As a resort, Asbury Park should, I feel, meet its obligations to our members, but more important still, help its Health Department to work effectively toward the control of a vicious disease. Our Venereal Disease Committee has written the Mayor, and the State Health Department has contacted the Commissioner directing the Health Department. "*Take Wassermanns in your office. Be eternally suspicious.*"

Drs. Clark, Jamison, Osborn, Rosenthal, and McKelvie are taking a post-graduate course in Venereal Disease Control at the Orange Memorial Hospital; and Drs. Alex Jordan and Joseph Carter are taking a course in the same subject at the University of Pennsylvania.

Cancer Control: Dr. William G. Herrman is the principal speaker at the "Cancer" Section of the New Jersey Health and Sanitary Association, 2:00 p.m., Friday afternoon, at the Berkeley-Carteret Hotel. Do you know how many milligrams of radium New Jersey may be assigned? How counties could and should handle their own curable and incurable diseases? and that a Cancer Clinic may be the objective in each county? It would be equally valuable to us, as physicians, to know about these points, along with the present incidence of cancer in Monmouth statistically, as also for health officers and well-trained nurses to know them.

The regular meeting of the *Monmouth County Medical Society* was held in the nurses' home of Fitkin Hospital, Wednesday, November 23rd. Dr. C. B. Blaisdell, of Long Branch, President, presided. There was an unusually large attendance present, among whom were members of the hospital intern staff and nursing staff.

SCIENTIFIC

The scientific session was divided into three parts:

1. Dr. William Cook Spain, Associate Professor of Clinical Medicine, College of Physicians and Surgeons, New York, "Allergy from the Point of View of the General Practitioner".

2. Showing a film on "Treatment in Pneumonia".

3. Lieutenant-Colonel Albert G. Hulett, President of New Jersey Chapter of the Association of Military Surgeons of the United States, gave an address on "Military Medicine".

The meeting was concluded about 11:30, following which a collation was served by the nurses of the hospital.

HEALTH AND SANITARY ASSOCIATION

A number of our members attended the various conferences and meetings of the New Jersey Health and Sanitary Association which were conducted on November 17th and 18 at the Berkeley-Carteret Hotel in Asbury Park, N. J. The outstanding feature of this session was an address made by Dr. Haven Emerson, who delivered a characteristic paper entitled "Signs of the Times in Public Health".

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A meeting of the *Morris County Medical Society* was held the evening of December 15 at the New Jersey State Hospital at Greystone Park, with President Thomas presiding.

EXECUTIVE COMMITTEE

The proceedings of the Executive Committee included the appointment of committee chairmen as follows:

Cancer Control Committee, Dr. Marshall B. Hogan.

Medical Advisory Committee to the Central Bureau of Social Service, Dr. George H. Lathrope.

Committee to group with the Morris County Welfare Board, Dr. Byron G. Sherman.

VENEREAL DISEASE CLINIC

Secretary Young announced that there would be a meeting with the Board of Chosen Freeholders on Friday, December 16, to urge the appropriation of money to cover the expense of the County Venereal Disease Control Clinic.

LEGISLATION

Dr. B. G. Sherman reported for the Welfare Committee, and recommended that the Uniform Medical Practice Act to be introduced in the Legislature at the approaching session be supported by the Medical Society; and this recommendation was approved unanimously.

INSURANCE

A talk on health and disability insurance was given by Mr. William Blanksteen of the National Casualty Company, Jersey City, who answered several questions regarding the Medical Society Group Disability Insurance.

SCIENTIFIC

The speaker of the evening was Dr. Stanley Nichols, Chairman of the Public Health Committee of the State Medical Society, his topic being "The New Jersey Physician of the Present and Immediate Future—His Private Practice and His Public Practice". Dr. Nichols presented his topic interestingly and impressively; and his address was followed by discussion.

After adjournment, refreshments were served in the hospital cafeteria.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Passaic City Club, Thursday evening, December 8, 1938, at nine p. m., with Vice-President L. G. Shapiro presiding.

NEW MEMBERS

Dr. Michael L. Keller, Paterson, was elected to active membership, and Dr. B. B. Burrill, Jr., Pompton Plains, and Dr. J. R. Schwartz, Fairlawn, to associate membership.

Dr. McBride, Chairman of the Legislative Committee, gave a report in reference to Bill No. 511, and urged that the doctors become familiar with it, and support the bill. The committee favors its re-introduction in the Legislature at the next session. The society unanimously voted to favor this bill at the next session of the Legislature.

MEDICAL-DENTAL SERVICE BUREAU

The following members were reelected to serve on the Board of Trustees of the Medical-Dental Bureau: Drs. Roemer, Ash, Dingman, Hall, Spickers, and Johnson.

MENTAL HYGIENE

Dr. Wassing, Chairman of the Mental Hygiene Committee, then introduced a resolution that the Board of Freeholders be urged to remedy the poor facilities for taking care of the mentally ill, juvenile delinquents, and criminal insane; that a psychopathic station be established in the county for the care of these cases; and that the County Medical Society act in an advisory capacity in handling this problem. This resolution was adopted.

OBSTETRIC DATA

Dr. Graham, of the Maternal Welfare Committee, requested a grant of \$38.50 to print 1000 forms to be used by the hospitals in the county for keeping accurate data on each obstetrical case handled. This was granted.

SCIENTIFIC

The speaker of the evening was Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell Medical School, and Professor of Internal Medicine, New York Polyclinic Medical School and Hospital, who spoke on "The Newer Aspects of Pneumonia Therapy".

Dr. Cecil reviewed the treatment of pneumonia, with particular reference to the use of serum, and showed by the analysis of many cases how the use of serum had cut the mortality in pneumonia. He mentioned the new drug, a derivative of *sulfanilamide*, which he had used in about forty cases, and that after a trial period in the various hospitals it was felt it had great possibilities in the treatment of pneumonia. He felt that perhaps the treatment with this drug, plus the serum, would be the ideal treatment.

Many questions were asked and a large attendance heard Dr. Cecil's talk with great interest.

The fourth Clinical Conference of the *Passaic County Medical Society* was held on Tuesday evening, December 20th, 1938, at the Paterson General Hospital at 9 p. m.

Dr. Louis G. Shapiro, President of the Passaic County Medical Society, opened the meeting with a few introductory remarks.

The Clinical session was conducted by Dr. Allen W. MacGregor. The program was "Interesting Cases from Orthopedic, Surgical and Gynecological Departments".

UNION COUNTY

Ronald J. Walsh, M.D., Reporter

The regular meeting of the *Union County Medical Society* was held at the Linden High School on November 16th, with President Henri Abel presiding.

CHINESE AID

The society was briefly addressed by a representative of the Chinese Aid Council, who appealed to the members for aid either through direct medical services, cash donations, or used instruments. He designated Mr. Otto Altenberg, of Elizabeth, as the local representative of the Council.

SCIENTIFIC

The address of the evening was given by Dr. Wells P. Eagleton. His subject was "The Medical Society of New Jersey in Relation to Medical Economics, and Its Efforts to Have the A. M. A. Formulate a National Health Program". (Jour., Oct., 1938, p. 624.)

He spoke eloquently of the glorious heritage of our medical past, and of the high standards and unshakable integrity of our medical ancestors, and gave a thumb-nail biography of the six physicians who signed the Declaration of Independence. He detailed the long uphill battle of the Welfare Committee to effect reforms, and pointed out that nearly twenty years ago clear-sighted members of the society saw the present crisis looming ahead, and proposed measures for its solution.

He deplored the apathy of the profession as a group, and this in the face of elaborate surveys which showed that in some parts of the country, at least, the medical care of the indigent is lamentably inadequate.

He attributed this apathy to poor leadership; to the fact that the A. M. A. House of Delegates does not control its own funds; and that the one meeting a year of the House of Delegates was used up with the routine business of the year, and had no time to discuss medico-economic problems.

Because of this, the A. M. A. was urged to hold a special session, and this finally took place on September 16th and 17th. Here was formulated a program responsive to the call of the times, and offering definite and satisfactory leadership to the swiftly crystallizing medical trend.

Dr. Eagleton's clear and forceful address was warmly received by the society.

MEDICAL-DENTAL BUREAU

Dr. E. P. Weigel urged that the threatened dissolution of the Medical-Dental Bureau should be postponed. He stated that the Bureau, with a permanent full-time secretary in charge, would discharge many valuable functions; as for instance, the more frequent publication of the *Bulletin*, the care of organization detail, the fostering of public relations, arranging addresses on medical topics before lay groups. Dr. Weigel's motion was adopted.

NEW MEMBERS AND OFFICERS

Dr. Joseph M. Gannon, Dr. Dehart Krans, and Dr. Phillip Owen were elected to the society.

The vacancy on the Board of Censors, unhappily left by Dr. Schlichter's resignation, was filled by Dr. Krans by unanimous vote.

Dr. Hoover was elected to fill the vacancy on the Finance Committee left by Dr. S. T. Quinn's death.

Dr. E. Z. Hawkes spoke briefly, giving Colonel Bigley the credit for the medical aspect of the E. R. A., and its working.

Dr. N. Burritt asked that the Committee on Public Health and Relations should be divided into three new committees: (a) Public Health, (b) Public Relations, (c) Legislative. This was directed to the proper channel.

The meeting was then adjourned, and was served a pleasant supper through the courtesy of the Linden Medical Society.

SUMMIT MEDICAL SOCIETY

Elwood H. Macpherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held at the Nurses' Home of Overlook Hospital November 29th. The meeting was called to order by the President, Dr. Hallock, with thirty members and eight guests present.

The society voted to purchase a Bausch and Lomb Balopticon which can be used both for standard slides and the projection of opaque objects as drawing or printed matter. A spring roller hanging model 8 x 8 white opaque screen was included.

The speaker of the evening was Dr. George Draper, Associate Professor of Clinical Medicine of Columbia University, who gave a most instructive talk on "Peptic Ulcer", emphasizing the nerve factor which is the true cause underlying these conditions. There was much discussion by various members present.

After the meeting a collation was served.

THE WOMAN'S AUXILIARY

Atlantic County

Reported by Mrs. Samuel L. Winn, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held November 11th, 1938, with Mrs. Andrew Smith presiding. There were twenty-three members and three guests present.

Reports were received from the Public Relations Chairman, Mrs. Ernest L. Shore, who states she has placed four speakers before lay groups this current month.

The Social Chairman, Mrs. Clarence Whims, urged full coöperation for the "Hill-Billy Supper Dance", to be held at the Northfield Country Club on November 19th, 1938. The proceeds from this party will benefit our Christmas funds which we distribute amongst various welfares.

It was decided to present a book to the Library in memory of Mrs. Samuel Barbash, who was one of the founders of the organization.

We had the extreme pleasure of having as our guest speaker Dr. William J. Carrington, President of The Medical Society of New Jersey. The subject of his talk was "Medicine in the News". Dr. Carrington states that the trend of the Government was toward socialized medicine, that a medical survey proved vastly different needs. The doctors are in complete agreement that the indigent should be taken care of, but not by that particular method. The government wants to spend an astronomical figure for medical relief, which he felt would tax the nation greatly, and which could be done by some modified method for much less. Taxation is great now, and would be a much greater burden to the already taxed. "No one gets anything for nothing", was his theme.

Dr. Carrington strongly urged all wives to be diligent in our efforts to make our husbands contented in order to make them better physicians, which in turn will react on the patients.

The December meeting and Christmas party of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at the home of Mrs. Clarence B. Whims, Ventnor, with the President, Mrs. Andrew Smith, presiding, and forty members and five guests present.

Preceding the business meeting, Assemblyman Vincent Haneman spoke on legislation.

The Social Committee reported its activities for the month: First the report from the Hill Billy Supper-Dance. This was a new adventure, and was well attended. Second was the announcement of a card and game party to be held at the Ambassador Hotel, Tuesday afternoon, January 10th, 1939. These parties are to reimburse our treasury so we may further our philanthropic endeavors.

The Public Relations Committee placed one speaker. It also urged all members to be prompt with the return of the questionnaires.

Our Christmas Cheer donations, amounting to \$80, were distributed among local organizations and charities.

Mrs. Daniel Reyner, our Public Health Chairman, informed us that all the rules for the contest have been sent out, and one hundred letters enclosing radio programs were included. These programs consist of broadcasts sponsored by the American Medical Association.

After the meeting we were delightfully entertained by a Christmas reading given by Miss Marjorie Schnell. Several Druid Carols were sung and explained by Mrs. Paul Gillespie and Mrs. Millard Bozarth.

A grand Christmas party concluded the pleasurable evening.

Bergen County

Reported by Mrs. Mark E. Branon, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held Tuesday evening, November 8th, 1938, at Bergen Pines Hospital, Oradell, with the President, Mrs. Walter Farr, presiding. Through a special effort on the part of the President and Executive Committee, a number of notices were sent to doctors' wives who have not been regularly attending the Auxiliary meetings, and as a result over forty members and guests were present.

We were honored to have Dr. W. J. Carrington, President of The Medical Society of New Jersey, speak to us on "Socialized Medicine".

Dr. S. T. Snedecor, of Hackensack, continued the discussion of the topic, giving us some very enlightening information on this important subject.

Following the speakers, a business session was held, during which routine reports were read and plans were formulated for a benefit bridge party to be held in March at Bergen Pines, with Mrs. A. B. Bickner, Chairman.

This year we are having but four regular meetings, so that we do not meet again until February, when Dr. Alexander will speak to us further on the subject of "Socialized Medicine".

A social hour was enjoyed, during which refreshments were served.

Essex County

Reported by Mrs. Frank S. Forte

The monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on Monday, October 24th, 1938, with Mrs. Gustave A. Braun, the President, presiding, and sixty members present.

Reports were received from:

Mrs. Anthony Ambrose, Corresponding Secretary, read a letter from Mrs. Theodor Teimer, thanking the Auxiliary for the flowers sent at the death of her husband.

Mrs. William Ferguson, Public Relations Chairman, reported that the Auxiliary coöperated with the Medical Society in sending out material for the A. M. A. survey. It also helped the Medical Society in mailing the material for the Clinical Conference, and in registering the doctors and driving them to and from the hospitals.

Mrs. George Scheller, Widows and Orphans Chairman, gave a résumé of the function of the Widows and Orphans Committee.

Mrs. Don A. Epler, Membership Chairman, reported that we had 251 members. Nine new members have been added since last May, as follows: Mrs. Edwin H. Albano, Mrs. Herman Busch, Mrs. William F. Grady, Mrs. Daniel E. Kavanaugh, Mrs. David A. Kraker (reinstated), Mrs. Paul A. O'Connor, Mrs. Maurice E. Scher, Mrs. J. G. Siegel, Mrs. Glenn L. Yates.

Mrs. Samuel Jessurun, Chairman of Clippings, requested the members to bring in all clippings on medical history and medical activities, as it was a request of the Essex County Medical Society.

Mrs. Don A. Epler, President of the Woman's Auxiliary to the State Medical Society, stated that at no time has our Auxiliary had a greater opportunity to justify its existence than now. With all this talk of Socialized Medicine, it behooves doctors' wives to keep well informed on health activities in lay organizations. Your Auxiliary has been supplied with a copy of an article on Socialized Medicine written by Dr. William J. Carrington, in which is stated the five points of the Federal Government, and we should all be familiar with it.

We are not organized wholly as a social group. We are, as our name implies, an aid to the Medical Society.

Mrs. R. T. Peabody, of the Curie Institute, spoke on Cancer Clinics. She was the speaker of the day.

The monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on Monday, November 28, 1938, with Mrs. Gustave A. Braun, the president presiding.

Mrs. Anthony Ambrose, Corresponding Secretary, read a letter from Mrs. Kenneth Forsythe, thanking the Auxiliary for a letter sent to Dr. Forsythe.

Mrs. William Ferguson, Public Relations Chairman, stated that she had five or six Doctors booked to speak at Parent Teachers Association.

Mrs. Francis Kerns, Program-Health Education Chairman, reported that Dr. Rita Finkler, would speak on *Endocrinology* at the January meeting. Tea will be served following the meeting.

Mrs. Edward A. Flynn, Chairman of Ways and Means, made a partial report on outcome of dance, which was successful both socially and financially.

The Board recommended that \$500.00 be turned over to the Essex County Medical Society for the permanent Benevolent Fund.

Mrs. R. H. Staehle, Chairman of Cheer, reported that flowers had been sent to Dr. Forsythe, and cards to mothers of new babies. A sympathy card was sent to Dr. Joseph Clarkin, on the death of his sister.

Mrs. Don A. Epler, Membership Chairman, reported eight new members since last month.

Mrs. Joseph P. Klenk

Mrs. Anthony P. Caggiano

Mrs. Marcus T. Block

Mrs. B. J. Silverstein

Mrs. Felix J. Di Finto

Mrs. Andrew Klein

Mrs. Paul H. Hosp

Mrs. Charles I. Nadel

Mrs. Don A. Epler recommended that a chairman be appointed for Medical History, and suggested that we collect data for the biographies of Doctors.

Gloucester County

Reported by Mrs. Ralph L. Moore

The *Woman's Auxiliary to the Gloucester County Medical Society* held a benefit card party on November 8th at the home of the President, Mrs. Frederick G. Wandall, in Clayton. This event was quite a success both socially and financially. The committee in charge was Mrs. Wandall, Mrs. Louis K. Collins, Mrs. William Pedrick, Mrs. Ralph C. Ventura and Mrs. Alfred G. Gillis.

The first fall business meeting was held Thursday, November 17th, at the Homestead, Woodbury, the president, Mrs. Wandall, presiding.

Officers for the year 1938-1939 are as follows:

President, Mrs. Frederick G. Wandall
President-Elect, Mrs. Baxter A. Livengood
Vice-President, Mrs. Chester I. Ulmer
Secretary, Mrs. Ralph C. Ventura
Treasurer, Mrs. Catherine Brewer

Committee chairmen appointed:

Membership, Mrs. Ralph K. Hollinshead
Finance, Mrs. Fuller Sherman
Public Relations and Publicity, Mrs. Ralph L. Moore
Program, Mrs. Elwood E. Downs
Health Education, Mrs. Isaac W. Knight
Widows and Orphans, Mrs. Chester I. Ulmer
Medical History, Mrs. Baxter A. Livengood

After the meeting, Mr. Marshall H. Diverty, son of Dr. Henry Diverty of the Medical Society, showed exceedingly interesting colored movies of his recent trip to Glacier National Park and the Canadian Rockies.

Hudson County

Reported by Nellie D. Nevin

The regular meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on October 7th, with Mrs. Charles B. Kelley presiding.

There were thirty-six members present; and two

new members—Mrs. Patrick Donnelly, and Mrs. Julius Africano—were welcomed.

A short business meeting followed at which satisfactory reports of all activities were given by the chairmen.

Instead of the usual guest speaker, a "Get-together" bridge and tea was enjoyed.

The Christmas Party of the *Woman's Auxiliary to the Hudson County Medical Society* was held on December 5th. Mrs. Charles B. Kelley, President, received the many members and guests.

The program opened with community singing and Christmas solos offered by Mrs. Costello, with Mrs. Harry Perlberg at the piano.

Miss Elsie Hubachek presented her "Christmas Cameo's".

The room presented a festive air with Christmas decorations at each window; and the tea table, over which Mrs. E. J. Chapman presided, was banked with red carnations and red candles.

Mrs. Henry Klaus, costumed as Santa Claus, was given a merry greeting as she presented gifts to all present.

Middlesex County

Reported by Mrs. M. B. Jacobson

The regular meeting of the *Woman's Auxiliary to the Middlesex County Medical Society* was held Wednesday, November 16, 1938, in New Brunswick, with Mrs. R. J. Faulkingham presiding in the absence of our President, Mrs. H. L. Strandberg. There were about thirty-five members present.

Mrs. William Stein, Chairman of Program, introduced our speaker, Miss Jessie Fiske, Professor of Botany at the New Jersey College for Women, who gave a most interesting and educational talk on "Mariajuana".

After the meeting, delicious refreshments were served.

The next regular meeting will be held in Perth Amboy and will be in the form of a Christmas party. Mrs. S. G. Berkow, of Perth Amboy, will be chairman.

Ocean County

Reported by Mrs. Emanuel M. Sickel

On November 14, 1938, the *Woman's Auxiliary to the Ocean County Medical Society* had its regular meeting at the Y. W. C. A. in Lakewood. Besides the members of the Auxiliary, there were representatives of all the Ocean County organizations invited to attend the discussion concerning the "Blood Transfusion Fund", recently established and sponsored by the Auxiliary.

This fund is to take care of payment to blood donors in cases of indigent patients, as well as private ones. Heretofore, the donor to the poor went unpaid. All money is held on deposit at a

local bank, and contributions can be made directly. The Auxiliary intends to budget itself so that the fund will receive the largest amount from its treasury each year.

The meeting was conducted by the President, Mrs. Robert Buermann. Among the speakers were Dr. Robert Buermann, Dr. Raymond Taylor, and Dr. E. M. Sickel.

Somerset County

Reported by Mrs. Charles F. Halsted

The regular meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held December 8th, 1938, with Mrs. Edgar T. Flint presiding. There were nine members present.

Reports were received from the Secretary, Mrs. Charles F. Halsted; and the Treasurer, Mrs. James L. Young.

Mrs. A. F. Sferra reported on the card party held in her home, at which forty-five dollars were realized.

Mrs. A. L. Stillwell reported for the Widows' and Orphans' Society.

The meeting was followed by a friendly get-together and refreshments.

Union County

Reported by Mrs. Herschel S. Murphy

On Tuesday evening, November 15, at *The Brook* in Summit, the *Woman's Auxiliary to the Union County Medical Society* held a supper dance in charge of Mrs. George Knauer, and Mrs. Victor du Busc, both of Elizabeth. It was a gala occasion and was well attended by members of the Union County Medical Society, Auxiliary and their friends. The Auxiliary hopes to make this an annual affair.

The *Woman's Auxiliary to the Union County Medical Society* met Wednesday evening, November 16th, at the home of Dr. and Mrs. Herschel S. Murphy, of Roselle. Prior to the business meeting, Dr. Norman W. Burritt, of Summit, spoke to the group on the topic of the "Pure Food and Drug Laws". He discussed the Wiley Bill and the Copeland Bill by citing different documental evidence. Dr. Burritt feels strongly that something should be done to get through better legislation to regulate the purity of food and drugs. The Copeland Bill, which took the place of the Wiley Bill, was passed under pressure and does not suffice the needs.

A short business meeting was conducted by the President, Mrs. D. R. McElhinney, of Elizabeth. Refreshments were then served by the hostess, assisted by Mrs. George Knauer, of Elizabeth. Mrs. H. V. Hubbard, Plainfield, and Mrs. F. B. Gilpin, Cranford, poured at the ends of the table, which was appropriately decorated for the Thanksgiving season with a large pumpkin filled with chrysanthemums and orange candles set in acorn squash candlesticks.



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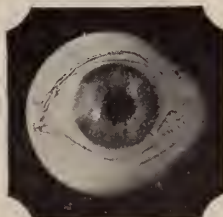
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Editorial and Executive Offices of the Society
143 EAST STATE STREET, TRENTON, N. J. TEL. 9330

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Committee —By-Laws, Chapt. VI, Sect. 1

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Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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ASHER YAGUDA, *Chairman*, Sub-Com. on Scientific Ex-
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Meetings

Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
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Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
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Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
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Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
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ELTON WALLACE LANCERahway
GEORGE O'HANLONJersey City
THOMAS KRAFFEL LEWIS, *Consultant*Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Industrial Injuries and Occupational Diseases

J. IRVING FORT, *Chairman*Newark
LESLIE EDWIN MYATT, *Vice-Chairman*Bridgeton
CHARLES LITWINTeaneck
TRAUGOTT JOHN SCHUCKHoboken
JAMES HERBERT SPENCER, JR.Franklin
WILLIAM FRANCIS COSTELLO, *Consultant*Dover
HENRY HOWARD KESSLER, *Technical Adviser*, representing
Commissioner J. J. Toohy, N. J. Dept. of Labor.....Newark
ROY GRIFFITH, *Technical Adviser*, representing the Manu-
facturers' Association of New JerseyGlen Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Legislation

BERTHOLD STEINBACH POLLAK, *Chairman*Secaucus
CHARLES HENRY MITCHELL, *Vice-Chairman*Trenton
WENDALL JONES BURKETTPitman
HERBERT ROY VAN NESSNewark
WILLIAM CRANE WILENTZPertb Amboy
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
Others at call of Chairman

Maternal Welfare

ARTHUR WALTER BINGHAM, *Chairman*East Orange
JOHN CARLISLE BROWN, *Vice-Chairman*Atlantic City
SAMUEL ALLISON COSGROVEJersey City
GEORGE BURTON GERMANCamden
CARL HALLER ILLNewark
JULIUS LEVYNewark
ROBERT ABBE MCKENZIEAsbury Park
WALTER BARCLAY MOUNTMontclair
JAMES HARRIS UNDERWOODWoodbury
HARRISON BETTS WILSONHackensack
THOMAS BENJAMIN LEE, *Consultant*Camden

Meetings

Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
January, 1939, Joint Meeting with County Ma-
ternal Committees and Field Physicians; date,
hour, and place to be selected by Chairman,
Dr. Bingham.

Medical Care of Indigent and Low-Wage Group

GEORGE WASHINGTON FITHIAN, *Chairman*Pertb Amboy
DAVID WRIGHT GREEN, *Vice-Chairman*Salem
FRANK L. FIELDFar Hills
DANIEL LEO HAGGERTYTrenton
WARREN DAVID ROBBINSCape May
BYRON GRANT SHERMANMorristown
EDWARD MATHIAS ZEH HAWKES, *Consultant*Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Medical Defense and Insurance

CHRISTOPHER CHARLES BELING, *Chairman*Newark
JOSEPH WALLACE HURFF, *Vice-Chairman*Newark
JOHN CHARLES MCCOYPaterson
GEORGE THOMAS TRACYBeverly
WILLIAM CARTER WESCOTTAtlantic City
WELLS PHILLIPS EAGLETON, *Consultant*Newark

Meetings

Atlantic City....May 19, 1938.....4 p. m.
Interim meetings at the call of Chairman
Trenton.....Apr. 16, 1939.....4 p. m.

Medical Practice

DAVID BACHARACH ALLMAN, *Chairman*Atlantic City
SPENCER TREADWELL SNEDECOR, *Vice-Chairman*.....Hackensack
HARRY NOAH COMANDONewark
GEORGE WASHINGTON FITHIANPertb Amboy
JACOB IRVING FORTNewark
WILLIAM WALLACE MAVERJersey City
RUBEN LORE SHARPCamden
CHESTER ISAAC ULMERGibbstown
ANTHONY CHARLES ZEHNDERNewark
THOMAS KRAFFEL LEWIS, *Consultant*Camden

Meetings

Atlantic City....May 19, 1938.....4 p. m.
Trenton.....Apr. 16, 1939.....4 p. m.
For meeting of Advisory Committees see their
schedules

Mental Hygiene

JAMES STUART PLANT, *Chairman*Newark
MARCUS ALBERT CURRY, *Vice-Chairman*Greystone Park
WILLIAM COLE DAVISAtlantic City
BARCLAY STOKES FUHRMANNFlemington
ALLEN GILBERT IRELANDTrenton
EDWARD SHEAFE KRANSPlainfield
CLARENCE MORTON TRIPPEAsbury Park
HERBERT WILLIAM NAFEE, *Consultant*New Brunswick
AMBROSE DOWD, *Technical Adviser*, representing Commis-
sioner Ellis, N. J. Department of Institutions and
AgenciesNewark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
One or two other meetings at call of Chairman

Nursing and Nursing Education

ANTHONY CHARLES ZEHNDER, *Chairman*Newark
GEORGE MILTON KNOWLES, *Vice-Chairman*Hackensack
HORACE WESLEY JACKCamden
VICTOR KNAPPAsbury Park
FRANK LESLIE PERRYWoodstown
HARRY SUBINAtlantic City
THOMAS J. FRANCIS WALSHElizabeth
WELLS PHILLIPS EAGLETON, *Consultant*Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Pharmaceutical Problems

CHESTER ISAAC ULMER, *Chairman*Gibbstown
REEVE LESLIE BALLINGER, *Vice-Chairman*Arlington
JACOB JOHN MANNPerth Amboy
MERWIN LESTER HUMMELMerchantville
CHARLES JOSEPH MURNPaterson
DANIEL WOOLSEY TELLER, JR.Morristown
RALPH KING HOLLINSHED, *Consultant*Westville

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Pneumonia Control

ROBERT ANTHONY KILDUFFE, *Chairman*Atlantic City
THOMAS MICHAEL KAINCamden
HENRY PAUL DENGLERSpringfield
MARSHALL FLOWER LUMMISPitman
FREDERICK THOMAS VOSBURGHPassaic
RALPH KING HOLLINSHED, *Consultant*Westville
WILLIAM MACDONALD, *Technical Adviser*, representing
Dr. J. Lynn Mahaffey, Director N. J. Department of
HealthTrenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Post-Graduate Education

DAVID FULLER BENTLEY, *Chairman*Haddonfield
STUART ZEH HAWKES, *Vice-Chairman*Newark
ALBERT WILLIAM PIGOTTSkillman
ERNEST FRANCIS PURCELLTrenton
HAMMELL PIERCE SHIPPSDelanco
SLOAN GRIFFIN STEWARTAtlantic City
CLARENCE WILTON WAYSea Isle City
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.

Public Health

STANLEY NICHOLS, *Chairman*Long Branch
FREDERIC WILLIAM LATHROP, *Vice-Chairman*Plainfield
FRANK A. BIENIrvington
ARTHUR WALTER BINGHAMEast Orange
CHARLES BYRON BLAISDELLLong Branch
JACOB IRVING FORTNewark
ERNEST GARFIELD HUMMELCamden
ALLEN GILBERT IRELANDTrenton
ABRAHAM EZRA JAFFINJersey City
ROBERT ANTHONY KILDUFFEAtlantic City
ISAAC WARNER KNIGHTPitman
JULIUS LEVYNewark
BARCLAY WELLINGTON MOFFATAsbury Park
HERSCHEL STRATTON MURPHYRoselle
HENRY BOYLAN ORTONNewark
JAMES STUART PLANTNewark
ELBERT STETSON SHERMANNewark
*THEODOR TEIMERNewark
EDWARD MATHIAS ZEH HAWKES, *Consultant*Newark

Technical Advisers

ELLEN POTTER and EMIL FRANKEL, representing Wm. G. Ellis,
N. J. Dept. Institutions and Agencies.
HENRY HOWARD KESSLER, representing J. J. Toohey, N. J.
Dept. of Labor.
WILLIAM MACDONALD, representing Director Mahaffey, N. J.
Dept. of Health.
HOWARD DARE WHITE, representing Director Elliott, N. J.
Dept. of Public Instruction.

Meetings

Long Branch.....July 10, 1938.....3 p. m.
Newark.....Sept. 7, 1938.....3 p. m.
Newark.....Oct. 5, 1938.....3 p. m.
Newark.....Nov. 2, 1938.....3 p. m.
Newark.....Dec. 7, 1938.....3 p. m.
Newark.....Jan. 4, 1939.....3 p. m.
Newark.....Feb. 1, 1939.....3 p. m.
Newark.....Mar. 1, 1939.....3 p. m.
Newark.....Apr. 5, 1939.....3 p. m.
Newark.....May 3, 1939.....3 p. m.

*Deceased.

Public Relations

JOSEPH HENRY KLER, *Chairman*New Brunswick
JOSEPH BERKELEY GORDON, *Vice-Chairman*Marlboro
GEORGE BARTON BARLOWEnglewood
EDGAR PARMELE CARDWELLNewark
HOMER ISAAC SILVERSVentnor
JACOB ALLEN YAGERPaterson
ELIAS JOSEPH MARSH, *Consultant*Paterson

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Publication

HENRY C. BARKHORN, *Chairman*Newark
EDWARD JOSEPH ILLNewark
JAMES LAWRENCE EVANSNorth Bergen
WILLIAM JOHN CARRINGTON, Ex-OfficioAtlantic City
ALFRED STAHL, Ex-OfficioNewark
FRANK OVERTON, EditorTrenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Newark.....July 27, 1938.....4:30 p. m.
Newark.....Aug. 31, 1938.....4:30 p. m.
Newark.....Sept. 28, 1938.....4:30 p. m.
Newark.....Oct. 26, 1938.....4:30 p. m.
Newark.....Nov. 23, 1938.....4:30 p. m.
Newark.....Dec. 28, 1938.....4:30 p. m.
Newark.....Jan. 25, 1939.....4:30 p. m.
Newark.....Feb. 22, 1939.....4:30 p. m.
Newark.....Mar. 29, 1939.....4:30 p. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Exhibits

ASHER YAGUDA, *Chairman*Newark
JAMES GORDON BOYES, *Vice-Chairman*Plainfield
NICHOLAS MARK ALTERJersey City
WILLIAM WOLF HERSOHNAtlantic City
LUTHER AGUSTUS MARKLEYTeaneck
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Program

CLARENCE LADELLE ANDREWS, *Chairman*Atlantic City
ROBERT SPEER GAMON, *Vice-Chairman*Camden
LOUIS CHARLES LANGEWeehawken
HARRISON STANFORD MARTLANDNewark
PAUL BRYSON REISINGERTrenton
WILLIAM JOHN CARRINGTON, *Consultant*Atlantic City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Study of Sterilization

CHARLES WRIGHT MACMILLAN, *Chairman*Passaic
SAMUEL EMLEN STOKES, *Vice-Chairman*Moorestown
WALTER JOHN FARRTeaneck
THEODORE RUSSELL ROBIEEast Orange
ALFRED FREDERICK SFERRABound Brook
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Traffic Accidents

ELBERT STETSON SHERMAN, *Chairman*Newark
MILLARD FREEMAN SEWALL, *Vice-Chairman*Bridgeton
THOMAS SIMON PADDOCK FITCHPlainfield
CHRISTIAN PETER SEGARDLeonia
GEORGE JOHN YOUNGMorristown
JESSE LYNN MAHAFFEYHaddonfield
WATSON BUDLONG MORRIS, *Consultant*Springfield
ARNOLD VEY, *Technical Adviser*, representing A. W. Magee, Commissioner of Motor Vehicles of N. J.Trenton

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Tuberculosis

ABRAHAM EZRA JAFFIN, *Chairman*Jersey City
SAMUEL BUDD ENGLISH, *Vice-Chairman*Glen Gardner
NORMAN WYVELL BURRITTSummit
LEO BERTHER DRAKEFranklin
CLYDE M. FISHPleasantville
MARCUS WARD NEWCOMBBrowns Mills
HAROLD SIMON HATCHMorristown
JOHN EDMUNDS RUNNELLSScotch Plains
HARRY BURTON WALKERVineland
FREDERIC JAMES QUIGLEY, *Consultant*Union City

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Venereal Disease Control

CHARLES BYRON BLAISDELL, *Chairman*Long Branch
MARSHALL DAVIS HOGANBoonton
BAXTER ALFONSO LIVENGODSwedesboro
STANLEY MARTIN MCGEEHANAtlantic City
ROBERT RAYMOND SELLERSNewark
STANLEY R. WOODRUFFJersey City
WILLIAM FRANCIS COSTELLO, *Consultant*Dover
ARTHUR JAY CASSELMAN, *Technical Adviser*, representing Dr. Jesse Lynn Mahaffey, Director of N. J. Dept. of HealthCamden

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Voluntary Health Insurance

EDWARD W. SPRAGUE, *Chairman*Newark
GEORGE B. GERMANCamden
ELTON WALLACE LANCERabway
WILLIAM C. RUCKERHackensack
FRANCIS HARRISON TODDPaterson

Welfare

HILTON SHREVE READ, *Chairman*Ventnor
WILLIAM JOHN CARRINGTON, *Ex-Officio*Atlantic City
ALFRED STAHL, *Ex-Officio*Newark
DAVID BACHARACH ALLMANAtlantic City
FRANK WILLIAM ASHPaterson
GEORGE BARTON BARLOWEnglewood
FRANK A. BIENIrvington
ARTHUR WALTER BINGHAMEast Orange
CHARLES BYRON BLAISDELLLong Branch
WENDALL JONES BURKETTPitman
NORMAN WYVELL BURRITTSummit
EDGAR PARMELE CARDWELLNewark
HARRY NOAH COMANDONewark
MARCUS ALBERT CURRYGreystone Park
WALTER JOHN FARRTeaneck
FRANK L. FIELDFar Hills
GEORGE WASHINGTON FITHIANPerth Amboy
JACOB IRVING FORTNewark
BARCLAY STOKES FUHRMANNFlemington
GEORGE B. GERMANCamden
JOSEPH BERKELEY GORDONMarlboro
DAVID WRIGHT GREENSalem
DANIEL LEO HAGGERTYTrenton

DONALD OSBORN HAMBLINBound Brook
HENRY HAYWOODNew Brunswick
EUGENE GARFIELD HERBENERLakewood
WILLIAM GETTIER HERRMANAsbury Park
ERNEST GARFIELD HUMMELCamden
ALLEN GILBERT IRELANDTrenton
ABRAHAM EZRA JAFFINJersey City
SIGURD WALTER JOHNSONPassaic
ROBERT ANTHONY KILDUFFEAtlantic City
JOSEPH HENRY KLERNew Brunswick
ISAAC WARNER KNIGHTPitman
FREDERIC WILLIAM LATHROPPlainfield
JULIUS LEVYNewark
CHARLES LITWINTeaneck
JOSEPH FRANCIS LONDRIGANHoboken
CHARLES WRIGHT MACMILLANPassaic
JACOB JOHN MANNPerth Amboy
WILLIAM WALLACE MAVERJersey City
CHARLES HENRY MITCHELLTrenton
BARCLAY WELLINGTON MOFFATRed Bank
HERSCHEL STRATTON MURPHYRoselle
LESLIE EDWIN MYATTBridgeton
STANLEY HETFIELD NICHOLSLong Branch
FRANCIS FRANCIS NORTONJersey City
BERTHOLD STEINBACH POLLAKSecaucus
WARREN DAVID ROBBINSCape May
MILLARD FREEMAN SEWALLBridgeton
TRAUGOTT JOHN SCHUCKHoboken
REUBEN LORE SHARPCamden
BYRON GRANT SHERMANMorristown
HOMER ISAAC SILVERSVentnor
SPENCER TREADWELL SNEDECORHackensack
JAMES HERBERT SPENCER, JR.Franklin
SAMUEL EMLEN STOKESMoorestown
*THEODOR TEIMERNewark
ADOLPH TOWBINLakewood
CHESTER ISAAC ULMERGibbstown
HERBERT ROY VAN NESSNewark
WILLIAM HENRY VARNEYWashington
HARRY BURTON WALKERVineland
WILLIAM CRANE WILENTZPerth Amboy
JACOB ALLEN YAGERPaterson
GEORGE JOHN YOUNGMorristown
ANTHONY CHARLES ZEHNDERNewark

Meetings

Trenton.....June 5, 1938.....1 p.m.
Trenton.....Oct. 2, 1938.....1 p.m.
Trenton.....Dec. 4, 1938.....1 p.m.
Trenton.....Feb. 19, 1939.....1 p.m.
Trenton.....Apr. 16, 1939.....1 p.m.

Woman's Auxiliary

GUSTAV AUGUST BRAUN, *Chairman*Newark
WILLIAM KING CAMPBELL, *Vice-Chairman*Long Branch
LOUIS FEINSTEINAtlantic City
GERALD ELLSWORTH McDONNELLMt. Holly
JOSEPH ROWLETT MORROWRidgewood
ALDRICH CLEMENTS CROWE, *Consultant*Ocean City

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Workmen's Compensation

HARRY NOAH COMANDO, *Chairman*Newark
JOSEPH FRANCIS LONDRIGAN, *Vice-Chairman*Hoboken
WILLIAM KLIPSTEIN HARRYMANHackensack
V. EARL JOHNSONAtlantic City
HENRY HOWARD KESSLERNewark
CEDRIC C. CARPENTERSummit
FREDERICK WILLIAM SHAFERCamden
DANIEL F. FEATHERSTONAsbury Park
ANDREW FRANCIS MCBRIDE, *Consultant*Paterson
STEPHEN J. LORENZ, *Technical Adviser*, representing J. J. Toobey, N. J. Dept. of LaborTrenton
ROY GRIFFITH, *Technical Adviser*, representing the Manufacturers' Association of N. J.Glen Ridge

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

HERRMAN, WILLIAM GETTIER, representing the M. S. of N. J. on the Board of Trustees of the Hospital Service Plan of N. J.

* Died Oct. 12, 1938.

WOMAN'S AUXILIARY

President, Mrs. DON A. EPLER, 45 Hillside Avenue, Newark, N. J.; Tel. Bigelow 3-7231

President-Elect, Mrs. G. E. McDONNELMt. Holly
First Vice-President, Mrs. A. E. JAFFINJersey City
Second Vice-President, Mrs. E. R. MULFORDBurlington

Recording Secretary, Mrs. BANKS S. BAKERCamden
Treasurer, Mrs. T. P. CONAGHYCamden

PRESIDENTS, SECRETARIES AND REPORTERS OF COUNTY SOCIETIES

County	President	Secretary	Reporter
ATLANTIC	James H. Mason, Atlantic City...	J. Carlisle Brown, Atlantic City.. Tel. 5-4979	E. H. Nickman, Atlantic City
BERGEN	Chester A. King, Oradell	G. Barton Barlow, Englewood Tel. Englewood 3-7121	LeRoy W. Black, Rutherford
BURLINGTON..	F. D. Fahrenbruch, Mt. Holly....	E. Warren Rodman, Beverly Tel. 32	Carlton P. Hogan, Burlington
CAMDEN	H. Wesley Jack, Camden	George B. German, Camden Tel. 7522	Harold D. Barnshaw, Camden
CAPE MAY	H. H. Tomlin, Wildwood	Warren D. Robbins, Cape May... Tel. 67	Warren D. Robbins, Cape May
CUMBERLAND.	Dare Woodruff, Vineland	H. S. Branin, Millville	E. S. Corson, Bridgeton
ESSEX	David A. Kraker, Newark	Marcus H. Greifinger, Newark ... Tel. Market 3-1918	Paul H. Hosp, Newark
GLOUCESTER..	William E. Crain, Woodbury	Chester I. Ulmer, Gibbstown Tel. Paulsboro 18	Henry B. Diverty, Woodbury
HUDSON	Reeve L. Ballinger, Arlington....	Thos. McG. Brennock, Jersey City. Tel. Journal Square 2-0787	John N. Connell, Jersey City
HUNTERDON ..	Barclay S. Fuhrmann, Flemington	E. W. Lane, Bloomsbury	E. W. Lane, Bloomsbury
MERCER	Thomas J. Walsh, Trenton.....	A. D. Hutchinson, Trenton	A. D. Hutchinson, Trenton
MIDDLESEX ..	Norman N. Forney, Milltown....	Estelle E. Kleiber, New Brunswick Tel. 7874	Howard Dieker, South River
MONMOUTH ..	C. Byron Blaisdell, Long Branch..	Dan'l F. Featherston, Asbury Park Tel. 3809	O. R. Holters, Asbury Park
MORRIS	Thomas S. Thomas, Jr., Morrist'n	George J. Young, Morristown Tel. 4-0662	Marcus A. Curry, Greystone P'k
OCEAN	Emanuel Sickel, Lakewood	William E. Dodd, Beach Haven .. Tel. 205	J. B. Henriksen, Point Pleasant
PASSAIC	Louis G. Shapiro, Paterson	J. Allen Yager, Paterson	Irving Okin, Passaic
SALEM	H. F. Suter, Pennsgrove	James S. Dunn, Salem	L. C. Hummel, Salem
SOMERSET	Edgar T. Flint, Raritan	L. C. Fritts, Somerville	Hayward F. Day, N. Plainfield
SUSSEX	James H. Spencer, Franklin	Jesse McCall, Newton	Edward K. Hawke, Newton
UNION	Henri E. Abel, Elizabeth	Lorrimer B. Armstrong, Westfield. Tel. 0077	R. J. Walsh, Roselle
WARREN	Clyde Smith, Oxford	William F. Skinner, Washington.. Tel. 10	H. B. Bossard, Phillipsburg

FIELD PHYSICIANS OF THE COUNTIES

County	Name	Address	Telephone
ATLANTIC	Ernest Shore	306 Atlantic Ave., Atlantic City	5-4550
BERGEN	Lyman Burnham	229 Engle St., Englewood	3-1810
BURLINGTON ..	F. D. Fahrenbruch	Mount Holly	237
CAMDEN	Edmund Hessert	Collingswood	607
CAPE MAY	Clarence W. Way	Sea Isle City	55
CUMBERLAND ..	J. S. Knowles	Millville	52
ESSEX	Alfred Muerlin	158 S. Harrison St., East Orange	Orange 5-9026
GLOUCESTER ..	Chester I. Ulmer	Gibbstown	Paulsboro 18
HUDSON	Joseph P. Donnelly	1 Madison Ave., Jersey City	Delaware 3-6682
HUNTERDON ..	P. W. Baker	High Bridge	170-R-2
MERCER	James R. Harman	824 W. State St., Trenton	3-0436
MIDDLESEX ..	Charles H. Calvin	80 Commerce St., Perth Amboy	4-0941
MONMOUTH ..	William Heatley	Red Bank	80
MORRIS	George L. Nicoll	Dover	180
OCEAN	George W. Gaumer	422 First St., Lakewood	81
PASSAIC	Theodore K. Graham	279 Park Ave., Paterson	Sherwood 2-9422 and 1607
SALEM	William G. Hilliard	Salem	332
SOMERSET	Samuel H. Pogoloff	Manville	Somerville 1228
SUSSEX	H. M. Aitken	Ogdensburg	Franklin 2002
UNION	Arthur E. Tator	57 DeForest Ave., Summit	6-0313
UNION (Colored)	C. DeFreitas	423 W. Fourth St., Plainfield	6-5332

S.M.A. - FOR INFANTS DEPRIVED OF BREAST MILK



S.M.A. CORP.
1938

When diluted according to directions, S.M.A. closely resembles human milk, *NOT ONLY* in the percentages of protein, fat, carbohydrate and ash, *BUT ALSO* in the chemical constants and in physical properties.

When fed to infants as a supplement, complement or as a complete substitute for breast milk, S.M.A. consistently produces excellent nutritional results comparable to those obtained with normal breast-fed infants.

The quick, easy method of preparing S.M.A. feedings is unusually simple. A Minute Mix Method Set together with complete directions will be sent Free to physicians on request.



S.M.A. is a food for infants . . . derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants and in physical properties.

S.M.A. CORPORATION • 8100 MCCORMICK BOULEVARD • CHICAGO, ILLINOIS



PROFESSIONAL
LIABILITY
PROTECTION

Afforded Members of

THE MEDICAL SOCIETY OF
NEW JERSEY

Since 1921

FAULHABER & HEARD, INC.

Authorized broker to negotiate
professional liability contracts for
The Medical Society of New Jersey

CONSULT US

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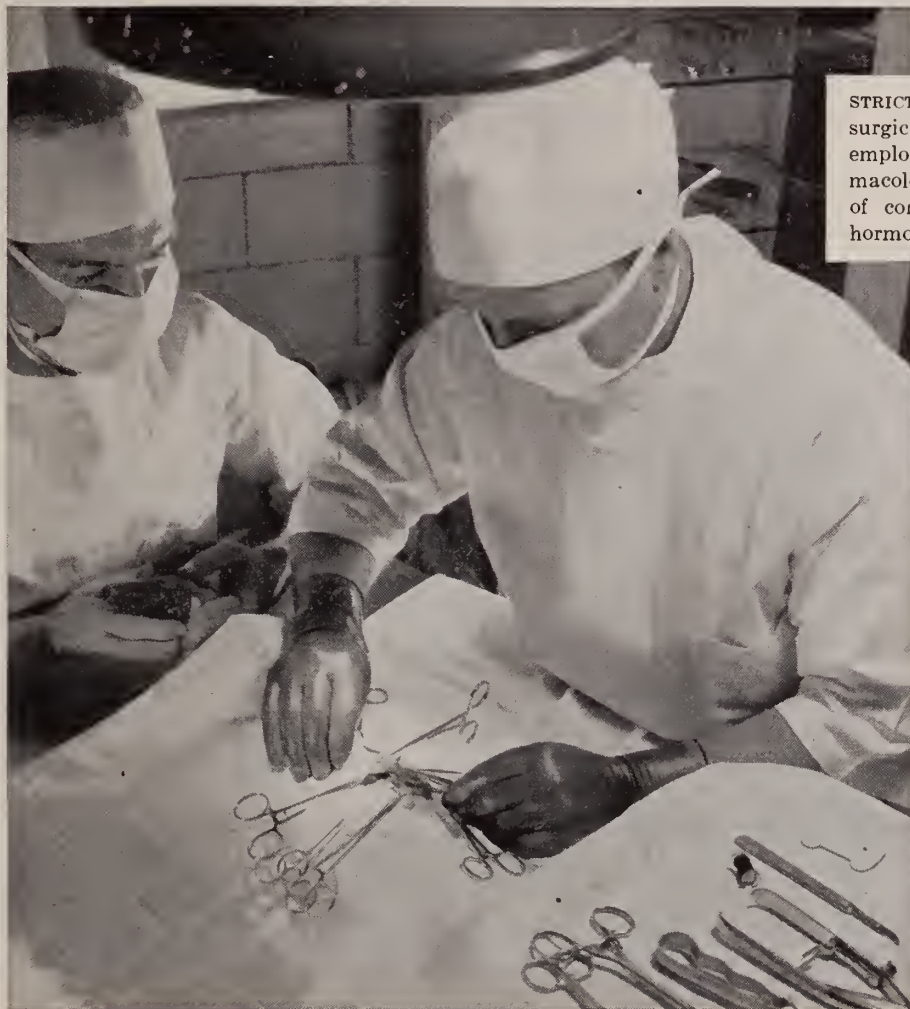
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- ☐ Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245
- ☐ Laryngoscope, 1935, XLV, 149-154
- ☐ N. Y. State Jour. Med., 1935, 35-No. 11, 590
- ☐ Laryngoscope, 1937, XLVII, 58-60

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FIVE YEARS OF CLINICAL STUDY and laboratory investigation of this serum have proved its value in the modification of the attack and the lessening of the dangerous complications of measles.

Two published reports^{1, 2} of this study are significant. Others are in preparation. These observations indicate that as little as 2 cc., if injected intramuscularly within 6 to 8 days after the initial intimate exposure, is effective in children under 2 years of age.

Older children require larger doses.

It is believed by some authorities that 2 to 3 times the indicated modifying dose will often prevent the attack entirely.

There is no satisfactory evidence available that an attack of measles can be modified by administration of any practical dose of Immune Globulin (Human) after the characteristic symptoms of the disease have appeared.

¹ Levitas, Irving M.: Treatment, Modification and Prevention of Measles by Use of Immune Globulin (Human), J.A.M.A., 1935, 105, 493.

² Laning, G. M. and Horan, T. N.: Immune Globulin Used as a Preventive and Modifier of Measles, Jour. Mich. Med. Soc., 1935, 34, 772.

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RECENT ADVANCES IN THE SCIENCE OF NUTRITION

VI. The Chemical Identification of Thiamin or Vitamin B₁

● An outstanding accomplishment of American Biochemical research has been the chemical identification—by degradation and by synthesis—of thiamin or pure vitamin B₁ (1). Thus, another dietary essential long known by its physiologic functions has been identified chemically, in this instance as a quaternary thiazole.

This discovery is of the most basic importance in the field of vitamin B₁ research. Determination of the chemical nature of this factor permits not only explanation of certain previously known facts concerning vitamin B₁, but in addition, has opened new fields of research. One of these is already concerned with the development of a reliable chemical method for estimation of thiamin which will be generally applicable to foods.

At present, quantitative determination of vitamin B₁ necessarily requires the use of one of the several bioassay methods available for that purpose. None of these is entirely satisfactory (1, 2). Perfection of a chemical method for quantitative measurement of thiamin in foods would add greatly to our knowledge of its occurrence in nature,

as well as permit more comprehensive studies of factors which might influence the stability of vitamin B₁ in foods. We have a relative paucity of such data relating to vitamin B₁ when the available information on vitamin C is considered.

It should also be stated that the synthesis of thiamin—which is now produced on a commercial basis—has already provided the clinician with a most useful diagnostic tool. Administration of the pure vitamin in cases of suspected thiamin deficiency, with notation of the therapeutic response, constitutes the most trustworthy means of detecting avitaminosis B₁. After the diagnosis has been confirmed and the immediate deficiency corrected by administration of thiamin, it is desirable that future adequate supply of vitamin B₁ be obtained through dietary readjustments (1).

In this connection, commercially canned foods deserve particular mention. Nutritional research (3, 4) on various members of this class of foods has demonstrated their potential value when included in a varied diet calculated to supply optimal amounts of vitamin B₁.

AMERICAN CAN COMPANY

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- (1) 1938. J. Amer. Med. Assn. 110, 727.
(2) 1938. Ibid. 111, 927.
(3)a. 1936. J. Nutrition 11, 383.
b. 1936. J. Amer. Diet. Assn. 12, 231.

- (4)a. 1932. J. Nutrition 5, 307.
b. 1932. Ind. Eng. Chem. 24, 457.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-fifth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



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For shrinking
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0.325 Gm.; oil of lavender, 0.097 Gm.; menthol,
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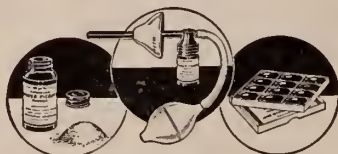
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THE RECENT Bridgeport studies encourage medical belief that constipation in children can, in many cases, be successfully treated by dietary measures alone. L. acidophilus milk proved beneficial in 81% of the cases treated.

A reprint of the complete findings of these studies (conducted by the Dept. of Bacteri-

ology of Yale University with the co-operation of the Bridgeport City Dispensary) may be obtained without charge by writing to the address below. They appeared under the title, "The Therapeutic Application of Acidophilus Milk in Constipation of Children", in the *American Journal of Digestive Diseases*, Vol. 5, pp. 170-173, May, 1938.

In prescribing an acidophilus milk, doctors will find the following facts of interest:

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For she knows that, at this time of year particularly, any cold may be the threshold of pneumonia. She knows that February shares with March the dubious honor of being a "pneumonia month;" that, together, they constitute the season of the year when pneumonia is most prevalent and most dangerous.

Throughout the next six or eight weeks especially, it will be wise to

take every possible precaution against pneumonia. Get plenty of rest—for pneumonia's greatest ally is fatigue. Avoid any over-exposure, particularly to extreme cold and dampness.

But above all, if anyone in your family has a cold and his or her temperature rises above normal, don't delay! Call your physician at once. Watch out, too, for chills, pain in the side or chest, and a cough. They, also, are danger signals that should be heeded promptly.

If your doctor is called at once, there is less to fear from pneumonia than ever before. Medical science can offer pneumonia patients more

help—can bring about more and quicker recoveries—than in any previous "pneumonia season."

But the pneumonia germ works fast, and every hour counts. If your doctor's treatment is to be most effective, he *must* be called early.

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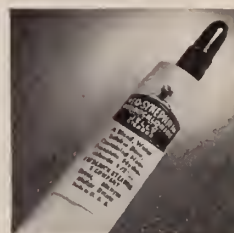
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY

UNDER THE
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COMMITTEE ON PUBLICATION



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THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

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EXECUTIVE OFFICER—LEROY A. WILKES, M.D.
EXECUTIVE ASSISTANT—NORMAN M. SCOTT, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. XXXVI, No. 2

FEBRUARY, 1939

Subscriptions, \$3.00 per Year
Single Copies, 30 Cents

EDITORIALS

Survey of Medical Services

The reports contained on the survey blanks which have been sent to each physician of New Jersey will be the basis for a composite picture of the need and the supply of medical care in the State; made according to the uniform plan of the American Medical Association. The sources of information on which the survey is based are three in number:

1. The reports of The Medical Society of New Jersey, and those of the State Departments and Bureaus, which have medical contacts and responsibilities, such as those of Health, Education, Labor, and other organizations whose functions are State-wide.

2. The reports of the activities of the county societies made on printed forms that are supplied by the A. M. A.

3. The reports of the practice of each individual physician regarding his report of his practice during a particular week.

The three sets of reports are closely inter-related. That of the State Society cannot be completed without the data which it receives from the county societies and the individual doctors. On the other hand, the store of information filed in the Executive Offices is at the disposal of the county societies and the individual doctors in making their reports.

Send us your preliminary report, using the data which you have, and we will send you the data that is in the office files.

You yourself are the only person that knows the details of the services which you render to your own patients, or the amount and kind of service which you donate to the poor. Your report will be held in confidence, and only the summaries will be published.

LEROY A. WILKES,
Executive Officer.

How much free service is given by doctors? Your report of your own experience is needed in order to answer the question.

Know Thyself

"To see ourselves as others see us", is a valuable asset to any man, particularly a family doctor. Dr. Oliver Wendell Holmes, who was as good a physician as a poet, wrote that each person is in fact a trinity of persons:

1. The person that his associates think he is.
2. The person that he thinks he is.
3. His own real self.

WHAT WELFARE ORGANIZATIONS THINK OF DOCTORS

Endowed welfare organizations and government agencies have spent years of effort and millions of dollars for the purpose of discovering the unsupplied needs of the people, and their reports have contained a dominant element of criticism, and often of condemnation of family doctors for failing to gratify the wishes of the people to obtain robust health by means of potent drugs and serums, and the practice of a popular regimen during a brief period of enthusiasm. The implication of these arguments is that if the government should supply medical services at public expense, the indifferent, pleasure-seeking citizen-patient will be transformed into a self-reliant, independent citizen, physically, mentally, and morally.

Practicing physicians know full well that they cannot accomplish miracles of character transformation by merely thinking they can.

WHAT DOCTORS THINK OF THEMSELVES

The great organization of physicians,—from the American Medical Association to the medical societies of the States and counties,—have been inclined to ignore the published diagnoses and opinions of the welfare organizations and government officials. But a change of attitude of practicing physicians was revealed suddenly and unexpectedly at the special meeting of the A. M. A. on September 16, 1938, when the delegates voted their unanimous endorsement of the government's *objective* to bring efficient medical service within reach of every citizen, regardless of his economic or social status; but at the same time the delegates also expressed their unanimous disapproval of the *methods* proposed for realizing those objectives.

Instead of being content to deny the *diagnoses* of the welfare organizations and government officials, the delegates gave their unanimous approval to the proposition to make their own unbiased investigation of the extent and the efficiency of the present methods of the distribution of medical service.

Instead of acting on guess-work, the physicians instituted a nation-wide survey of the extent of their own efforts and the responses of their local communities to their suggestions.

SELF-ANALYSIS

Probably no doctor is either as good or as bad as he thinks himself to be in his moments of calm reflection.

Neither is any doctor as bad as one might judge from the remarks that are frequently overheard in the smoking room of the hospital or the anteroom of the medical society meeting where adverse criticism rather than praise is a popular topic of conversation.

The real fact is that physicians are more conscientious and devoted to the relief of the physical and mental ills of mankind than any other group of citizens.

The misunderstandings regarding the doctor's objectives and methods arise largely from his own disinclination to "Take an account of stock", along two lines:

1. The actual needs of the people,—particularly of those who are either unwilling or unable to conform to the doctor's diagnosis and treatment.
2. The amount and kind of effort which the medical profession is putting forth to meet those needs.

THE DOCTOR AS HE REALLY IS

A method of surveying medical practice as it actually exists has been developed by the A. M. A., and adopted by the medical society of every State. The fundamental element in the study is that each physician should survey his own practice for a particular week, answering such simple questions as:

How many pay patients did you see?

How many did you treat at reduced rates?

How many did you treat free?

The essential value of this survey depends on the response of every individual doctor in surveying his own practice.

When it is completed, it will visualize the actual practice of every individual physician, and will be a basis for estimating the extent to which the physicians are meeting the real medical needs of the people.

The survey will also reveal the extent of the

services in which the participation of the community is needed, such as those of expert consultants, hospitalization, nursing, and visitation, and the various forms of relief both social and financial.

Have you made out your individual report?

If you have not already made it out, will you prepare it and send it to the Executive Officers of The Medical Society of New Jersey before February 15th?

Reports of Presidents of County Societies

The medical profession of New Jersey is organized in a regiment of 3500 physicians, which is composed of twenty-one companies each with an average number of 175 members.

ORGANIZATION

The executive officers of the regiment are the President and his staff, who are chosen by the votes of delegates from the county societies. These delegates also decide the objectives of the State Society and uniform methods of attaining them.

The local field operations of the enlisted companies are conducted under the leadership of the *county society officers*, who are chosen by the members themselves.

The efficiency of the field operations of the medical army depends on two factors:

1. The wisdom of the officers of the State Society, who determine the general scope of the companies' plans and operations.

2. The coöperation and leadership of the officers and members of the county societies in adopting the details of the companies to local conditions.

MEANS OF COMMUNICATION

The official means of communication among the units and members of the medical army are:

1. The monthly issues of the Journal of The Medical Society of New Jersey, and the printed bulletins of the county societies.

2. The annual reports of the officers and committees of the State Society.

In addition to these two sources of information, the House of Delegates has voted to request Presidents of each county society to submit an annual report of the progress of his society during the past year. (Transactions, 1938, pages 12, 51 and 53.)

SUBJECTS FOR PRESIDENTS' REPORTS

The Presidents will find that a practical source of information regarding subjects for their reports is the department of *County Society Reports* in the Journal,—105 reports being listed in the index during the year 1938 (Jour., Dec., 1938, p. 778). Among the important activities which are described are the following:

Baby Keep-Well Stations
Broadcasts
Cancer Control
Care of Indigents
Graduate Education
Health Projects
Legislation
Medical Economics
Nursing
Pneumonia Treatment
Venereal Disease Control

From these and other topics each President can choose the subjects for an annual report that will be both informative and interesting.

The survey of your own practice will be confidential. Send it at once.

Is medical service adequate? The survey of your own practice will help supply the answer.

Five Years of Progress

This issue of The Journal completes five years of the record of The Medical Society of New Jersey since the establishment of its executive and editorial offices.

Five years ago it was difficult to obtain a sufficient amount of material to make up a Journal that would be worthy of an active State Society. Now the amount of material is so great that the difficulty lies in choosing the material from among the great number of the excellent studies and reports of the officers and committees.

THE SCIENCE OF ADMINISTRATION

The administration of the affairs of The Medical Society of New Jersey has developed into a science as important as that of physiology and pathology. Each of the thirty committees has made an amount of study and decisions that is comparable to that of the entire Society a few years ago. Under the new regime, the President is in very fact the *Director of Activities*, who exercises his prerogative of requiring every chairman of a committee and every member to produce results that are tangible. The requirement is in the first place to make a clear *diagnosis* of the conditions which are under investigation, and then to prescribe a definite treatment for their improvement.

THE COUNTY SOCIETIES

Five years ago there was an undercurrent of protest against the so-called "Dominance" of the State Society. Now the current reports of the meetings of the county societies are full of records of their hearty coöperation with the State Society. This happy result has been brought about by the custom of choosing the chairmen and members of the committees from among those county society members who have demonstrated their efficiency in the administration of their home county societies.

THE MEMBERS

During the past five years a spirit of *scien-*

tific administration has grown among the individual members of the county societies. The majority of the members now realize that they have definite duties to perform for the benefit of the *community* as well as their *private patients*. Every county society is becoming a *research laboratory* in order to discover the needs of the people, and to devise the particular methods by which those needs can be supplied. Every county society is rapidly becoming a *school* of medical administration in which every member is enrolled.

SURVEYS

The extensive surveys which have been conducted by endowed organizations and governmental agencies have been investigations of conditions which were prevalent among the people ten years ago; and they have not included the very great improvements in medical administration which have been demonstrated by the medical societies, and whose results have become particularly evident during the past five years. If the investigators would survey the activities of the county and State societies during the past decade,—particularly the past five years,—they would find that the progress has been as rapid as might reasonably be expected.

The Journals of the State Medical Societies are *source material* which the investigators would do well to study, for they are the repositories of the records of the high aspirations and achievements of the members. It would also be profitable for every welfare investigator to spend a week in the Executive Offices of The Medical Society of New Jersey and listen to the inquiries which are constantly coming in by letters and telephone, and the answers to requests for advice as to how to deal with perplexing situations. By this means the observer would gain a new conception of the great extent and high standard of the work which the medical societies are performing quietly and spontaneously.

Have you balanced your opportunities against your accomplishments? Be sure to fill out your survey blanks at once.

ORIGINAL ARTICLES

RECURRENT DISLOCATION OF THE SHOULDER

By TOUFICK NICOLA, M.D., F.A.C.S., Montclair, N. J.

From the Orthopedic Department, Mountainside Hospital, Montclair, N. J. Read before the Surgical Section of the Annual Meeting of The Medical Society of New Jersey on May 17, 1938.

From the pathological standpoint, most of the cases of recurrent dislocation of the shoulder that we see follow a traumatic dislocation. They may be anterior or posterior. In the anterior group we have—

1. Subglenoid—lower anterior
2. Subcoracoid—middle anterior
3. Subclavicular—high anterior

In the posterior group we have—

1. Subacromial—middle posterior
2. Subspinous—high posterior

If the problem of recurrent dislocation was limited to a torn or relaxed capsule, it could be easily solved by suturing this torn or relaxed capsule. However, we have other conditions to contend with, namely:

1. Weakness of muscles around the shoulder either from tears or disuse.
2. Contracted pectoralis major, teres minor, and latissimus dorsi.
3. Defects in the head of the humerus, either acquired after the first dislocation, or due to atrophy of the head.
4. Defects in the glenoid cavity either acquired after fracture of the edge, or shallowness of a congenital type.
5. Fractures of the greater or lesser tuberosities of the humerus.

From the pathological consideration, it is seen that in most cases there is usually a combination of two or three factors present; and to repair one leaves a loophole for recurrences. To repair all is very difficult and sometimes impossible. The following operation is in principle the same as the original, but has a few improvements and is described in more detail.

DESCRIPTION OF OPERATION

1. The incision begins just outside of the coracoid process and passes downward for

three inches in the line of the fibers of the deltoid.

2. The deltoid fibers are divided by blunt dissection. At this point the circumflex nerve and artery may come into view, crossing the wound. If so, care should be taken to avoid injuring them.

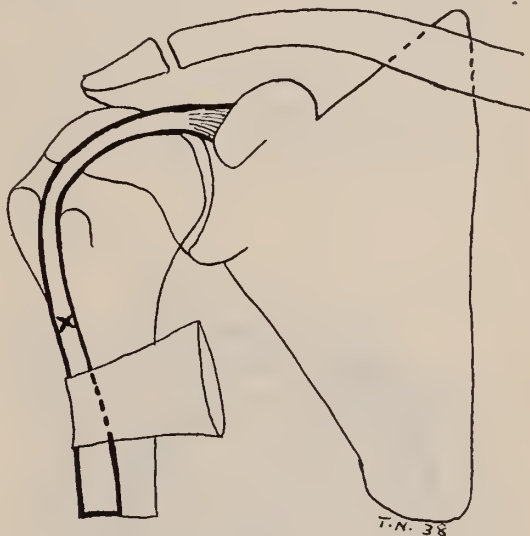


FIGURE 1

Shows line of direction of long head of biceps tendon.

3. The tendon of the long head of the biceps is located by feeling for the bicipital groove, which lies between the tuberosities of the humerus. A small nick is made through the transverse humeral ligament in the line of the tendon underneath. At this point, if the tendon seems small or if the patient is very heavy or muscular, it is possible to reinforce the tendon with that portion of the capsule which lies over it. (This latter idea was suggested to the author by Bailey, of Boston.) A blunt scissors is then inserted into this small opening and the tendon is exposed up

into the shoulder joint by dividing the transverse humeral ligament which holds the tendon in the groove.

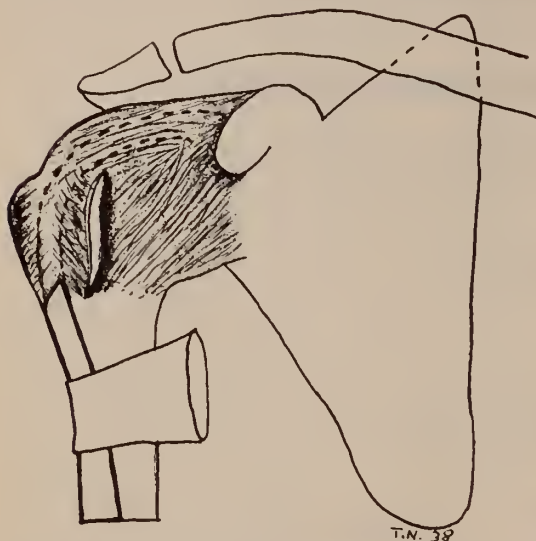


FIGURE 2

Shows capsule and transverse humeral ligament overlying the tendon.

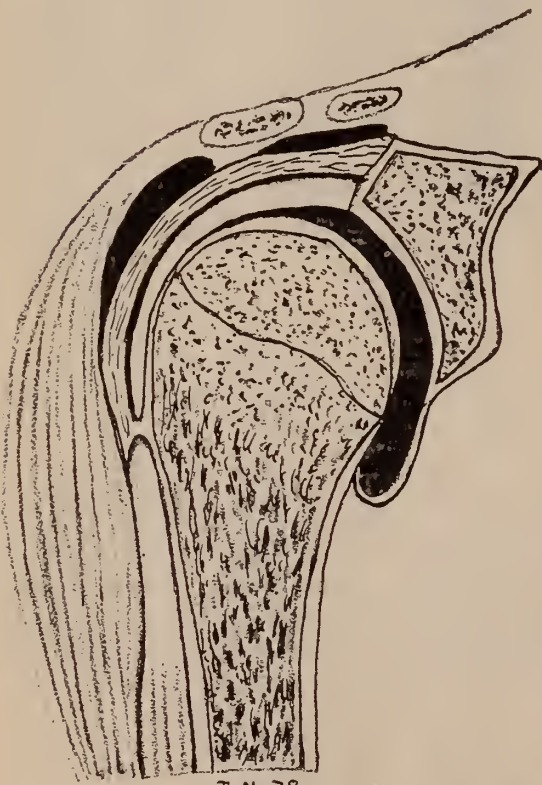


FIGURE 3

Shows relation of capsular ligament to long head of biceps.

4. Lift up tendon with a curve clamp, and remove the synovial sheath from the tendon by scarifying with a scalpel. This helps to insure its fixation in the tunnel.

5. After two stay black sutures are placed through the tendon of the long head of the biceps brachii, about one-half inch above where it dips below the tendon of the pectoralis major,

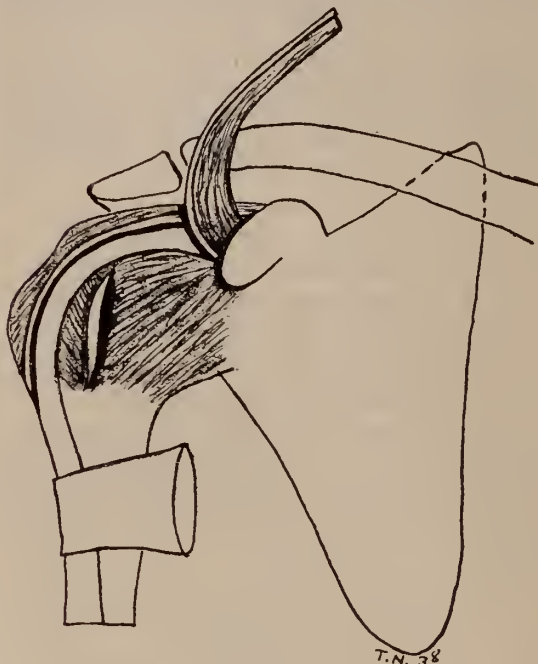


FIGURE 4

Capsule over long head of biceps reflected up to its attachment to the rim of the glenoid.

it is divided. If this is not done, the distal part will disappear below the tendon of the pectoralis major muscle, thereby prolonging the operation.

6. By means of a quarter-inch gouge, a hole is then put through the head of the humerus, beginning in the bicipital groove about one inch distal to the lesser tuberosity. The gouge should be so directed that it comes out on the articular head of the humerus in the line of the direction of the tendon, from one-half to three-quarters of an inch from the edge of the articular cartilage. If the head of the humerus dislocates when the arm is in outward rotation, the hole in the head should come out more anterior; and if in internal rotation, the hole should come out more posterior.

Note: If it comes out less than one-half

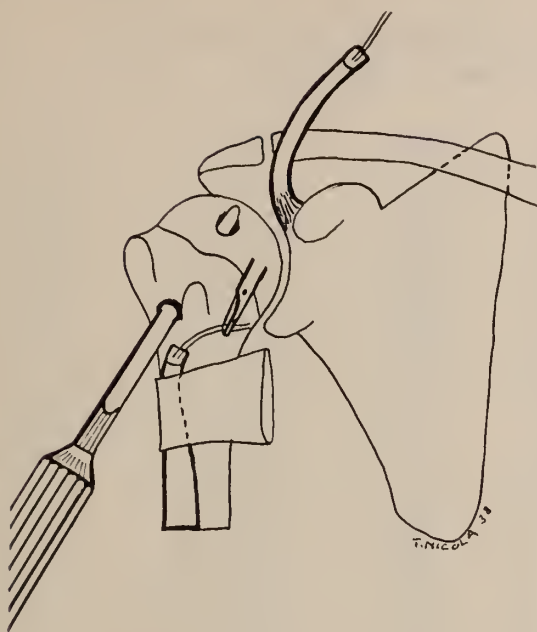


FIGURE 5

Gouge passed through bone to come out at least one-half inch from periphery of articular surface of the head of humerus.

inch from the edge of the articular cartilage, there is a chance for recurrence of the dislocation, because the tendon will not check the arm in extreme abduction. If fixed in the bicipital groove, the tendon will not check the arm until it reaches from 255 to 280 degrees of abduction. This abduction cannot be reached without dislocating the shoulder. The usual maximum of abduction of a normal shoulder is ninety degrees, and combined with the scapular movements, the abduction of the shoulder reaches a maximum of 180 degrees.

7. The gouge is then withdrawn and the loose bone marrow is removed from its cavity. The bicipital groove, just distal to the tunnel, is gouged out for about one inch to insure fixation of the long head biceps. The gouge is reinserted, and an eighteen-inch piece of tonsil wire folded on itself is passed through the tunnel from its distal end. The wire is then lifted up through the shoulder joint and the loop is threaded with black silk which is attached to the proximal part of the divided

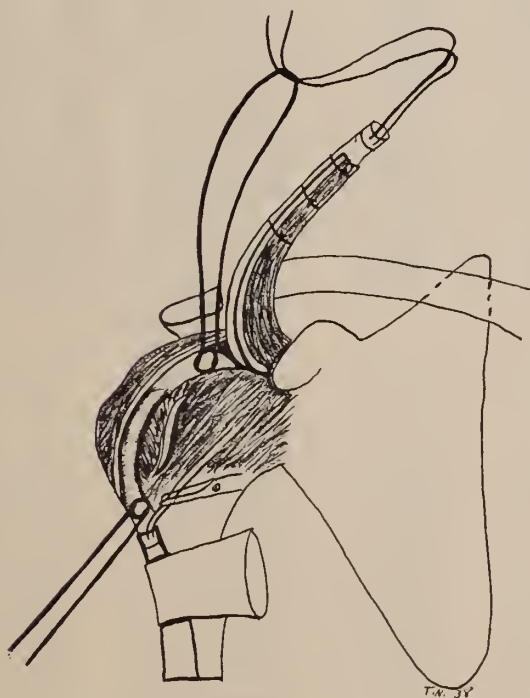


FIGURE 6

Reflected capsule sewed to proximal portion of the tendon for reinforcement.

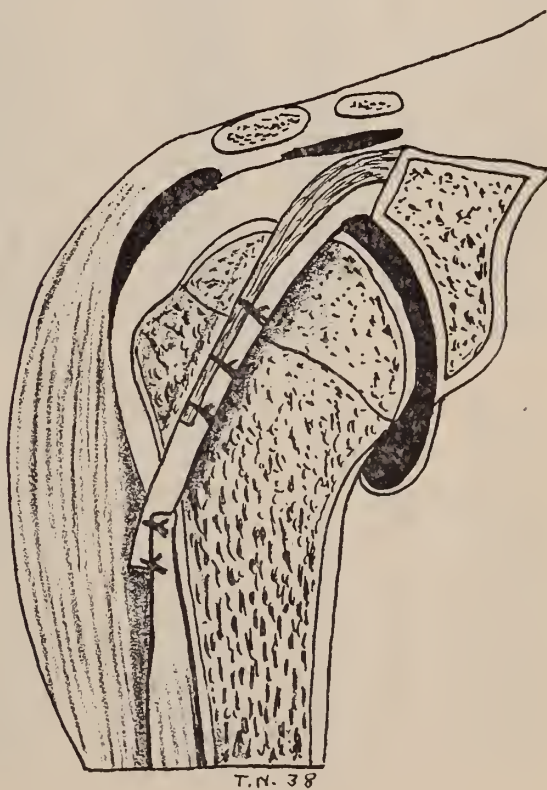


FIGURE 7

Tendon and capsule drawn through tunnel in bone and sewed to distal end of tendon.

SUMMARY OF FIFTY-EIGHT CASES IN WHICH OPERATION WAS PERFORMED
FOR RECURRENT DISLOCATION OF THE SHOULDER

Name	Age	Sex	Occupation	Number of Dislocations	Shoulder Affected	Date of Operation	Stay in Hospital
Case 1	20	M	Boxer	5—weekly	Right	April 6, 1928	6 days
Case 2	27	M	None	2—weekly	Left	Sept. 8, 1928	10 days
Case 3	20	F	Student	6—weekly	Right	May 14, 1929	10 days
Case 4	25	M	Salesman	1—monthly	Right	Nov. 5, 1929	10 days
Case 5	21	M	None	7—weekly	Right	Nov. 17, 1929	14 days
Case 6	18	F	Student	1—monthly	Right	Dec. 4, 1929	10 days
Case 7	30	M	Painter	1—weekly	Right	March 3, 1930	14 days
Case 8	50	M	Physician	1—monthly	Right	April 4, 1930	21 days
Case 9	24	M	Salesman	1—monthly	Left	April 21, 1930	10 days
Case 10	17	F	Student	4—weekly	Left	June 24, 1930	14 days
Case 11	24	M	Clerk	3—weekly	Right	July 8, 1930	10 days
Case 12	28	M	Plumber	2—weekly	Right	July 8, 1930	14 days
Case 13	35	F	Housewife	1 in 2 weeks	Right	Sept. 4, 1930	14 days
Case 14	29	M	Laborer	1 in 2 months	Right	Feb. 7, 1931	10 days
Case 15	21	M	Student	4—yearly	Left	Feb. 9, 1931	6 days
Case 16	40	M	Laborer	5—monthly	Right	June 6, 1931	14 days
Case 17	19	M	Baseball	1—monthly	Right	June 6, 1931	10 days
Case 18	20	M	Student	4—yearly	Right	June 30, 1931	8 days
Case 19	29	M	Laborer	3—monthly	Right	Aug. 4, 1931	14 days
Case 20	24	M	Student	8—yearly	Right	March 20, 1932	7 days
Case 21	29	M	Plumber	4—monthly	Right	May 4, 1932	18 days
Case 22	37	M	Laborer	3—weekly	Right	Jan. 4, 1933	21 days
Case 23	17	F	Student	9—yearly	Left	April 9, 1933	10 days
Case 24	22	M	Student	6—yearly	Left	April 14, 1933	6 days
Case 25	20	M	Student	6—monthly	Right	May 7, 1933	9 days
Case 26	38	M	Laborer	1—monthly	Right	June 9, 1933	14 days
Case 27	20	M	Student	4—monthly	Right	July 11, 1933	10 days
Case 28	19	F	Housewife	9—monthly	Right	July 11, 1933	17 days
Case 29	26	M	Laborer	4—weekly	Left	Sept. 7, 1933	14 days
Case 30	41	M	Laborer	1—weekly	Right	Sept. 14, 1933	21 days
Case 31	38	M	Lawyer	4—monthly	Left	Sept. 14, 1933	14 days
Case 32	24	M	Student	1—monthly	Both	Oct. 3, 1933	10 days
Case 33	20	M	Student	1—weekly	Right	Oct. 2, 1933	7 days
Case 34	24	M	Student	4—weekly	Left	Nov. 3, 1933	5 days
Case 35	21	M	Student	2—weekly	Left	Nov. 3, 1933	7 days
Case 36	30	F	Clerk	1—weekly	Right	Dec. 29, 1933	7 days
Case 37	16	M	Student	5—weekly	Left	March 2, 1934	9 days
Case 38	17	F	Student	1—weekly	Right	March 16, 1934	7 days
Case 39	22	M	Student	1—weekly	Both	June 3, 1934	5 days
Case 40	34	M	Business	2—weekly	Right	June 10, 1934	7 days
Case 41	22	M	Student	4—weekly	Right	June 17, 1934	7 days
Case 42	39	M	Laborer	2—weekly	Right	June 17, 1934	7 days
Case 43	29	M	Laborer	2—weekly	Right	Redislocated, reoperated with fascia and short head	7 days
Case 44	24	F	Business	1—weekly	Left	July 10, 1934	7 days
Case 45	22	M	Student	1—weekly	Right	Redislocated, not reoperated	5 days
Case 46	25	M	Business	6—weekly	Left	Sept. 10, 1934	6 days
Case 47	24	M	Business	1—weekly	Right	April 4, 1935	7 days
Case 48	32	M	Laborer	3—weekly	Right	May 7, 1935	7 days
Case 49	19	M	Student	3—weekly	Right	July 6, 1935	14 days
Case 50	21	M	Student	5—weekly	Left	July 17, 1935	7 days
Case 51	17	M	Student	7—weekly	Right	Sept. 4, 1936	9 days
Case 52	35	M	Business	1—weekly	Left	Oct. 3, 1936	7 days
Case 53	20	M	Student	1—weekly	Left	Nov. 9, 1936	7 days
Case 54	19	M	Boxer	3—weekly	Right	Jan. 4, 1937	10 days
Case 55	24	M	Baseball	2—weekly	Right	Aug. 14, 1937	7 days
Case 56	31	M	Laborer	2—weekly	Left	Nov. 4, 1937	7 days
Case 57	19	M	Student	1—weekly	Right	Nov. 9, 1937	7 days
Case 58	46	M	Business	8—weekly	Left	March 14, 1938	7 days

tendon. The tendon is then drawn through the tunnel and united to the distal part by means of the black silk which has passed through the tendon before it was divided.

8. The arm is then abducted to a right angle and the transverse humeral ligament is sutured to that part of the tendon of the long head of the biceps which lies in the bicipital groove. This does two things: (1) It insures enough tendon from the head of the humerus to the glenoid cavity, thus removing any restriction of normal abduction; (2) it holds the tendon from moving up and down in the tunnel, and hastens its fixation in the tunnel.

9. The transverse humeral ligament and the capsule are sewed with continuous number one plain catgut sutures; the split deltoid muscle with a few interrupted sutures. In women the skin is closed with skin clips or a subcuticular stitch. Many of the skin scars have spread or formed keloids. To avoid this, care should be taken in sewing up the layers carefully.

10. The shoulder is then put in a simple Velpeau bandage reinforced with adhesive plaster, with the arm close to the chest and the elbow flexed to forty-five degrees. This position is maintained for two weeks. In epileptics it is wise to keep the shoulder immobilized for at least six weeks.

11. After removal of the Velpeau, the patient carries a sling and has muscular exercise to muscle-bind the shoulder. The author feels the omission of this may account for some of the recurrences following operation. An effective exercise consists of squeezing a rubber

ball against the chest with the elbow. This is done twenty-five times, twice daily.

Of the three cases in this series which redislocated after operation, two were reoperated.

Case 1—Redislocated in seven months. It was found that the hole in the humerus was too large, resulting in lack of fixation of the tendon and its fraying out. To avoid this, make hole smaller and fix tendon in the bicipital groove as described in step 8.

Case 2—Redislocated in five months. In this case the patient had been previously operated upon, using the peroneus longus as a suspensory ligament. He weighed 260 pounds. This case should have had the tendon of the long head reinforced with capsule as described in step 3. He also should have had postoperative exercises to muscle-bind his shoulder. In this case, half the short head of the biceps fascia were passed through the greater tuberosity and the acromion.

I wish to express my appreciation to Dr. Peter Cordasco for his work on the bibliography.

CONCLUSION

1. The operation is simple.
2. It can be used in all cases, whether the pathology be bony, capsular or muscular.
3. There is practically no restriction of motion of the shoulder.
4. Convalescence is short.
5. Enough time has elapsed to prove that this operation is dependable.

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DIAGNOSIS AND TREATMENT OF MALIGNANT DISEASES OF THE NOSE AND NASAL SINUSES

By LEROY A. SCHALL, M.D., Boston, Mass.

Read before the Eye, Ear, Nose, and Throat Section of The Medical Society of New Jersey, at its Annual Meeting, on May 17, 1938, in Atlantic City.

If any apology were needed in choosing my subject, I might base it on the fact that the recognized textbook on diseases of the nose that I studied as a medical student contained but six lines on the subject of tumors of the nasal sinuses. This is a dire disease, and it deserves more attention than that given to it twenty odd years ago. It is a challenge to the rhinologist; it challenges his diagnostic acumen, his judgment in prescribing, and carrying out treatment, and it challenges his patience through the months and even years of following his patient. It too is a challenge to the patient—it calls for major surgery with months of pain and discomfort, with years of observation. The treatment is frequently disfiguring, and only too often there are recurrences that fail to respond to any treatment.

If I can bring any message to you, it is the necessity of a thorough examination of every patient, no matter how trivial his symptoms may appear. The errors of diagnosis are the results of failure in making a thorough examination. I speak from personal experience. I became interested in malignant disease by missing the real cause of a patient's complaint.

This patient was the president of one of our insurance companies. He was a big, florid man who, after playing golf in the rain, complained of his nose being obstructed and a blocked ear. I saw him at home in bed. I found a badly congested nasal mucous membrane, and an acute secretory otitis. After my remedies failed to relieve his condition, he saw one of my confreres, who refused to see him at home, but insisted upon an office examination where, with a post-nasal mirror, a large mass was seen in the naso-pharynx. This was epidermoid carcinoma, grade two.

When one is connected with a tumor clinic, he is impressed by the number of patients who have been treated, and often operated upon, for conditions other than cancer. I could cite case after case of a submucous resection which did not relieve a nasal obstruction caused by a post-nasal growth; of antral washings that accelerated a maxillary sinus growth; or ton-

silectomies for a pyriform sinus malignancy. One of the great benefits of the educational campaign is to make, not only the patient, but the attending physician *cancer conscious*.

SYMPTOMS

When a new growth is limited to the nasal cavity, nasal obstruction and hemorrhage are the most frequent symptoms. A small growth of the anaplastic type with thin-walled blood vessels may show early ulceration with subsequent hemorrhage as its first symptom. With the increase in size of the growth, nasal obstruction occurs. This obstruction is usually unilateral, so it is an axiom that any unilateral obstruction by a growth should be considered malignant until the microscope proves it otherwise. When the tumor is of the slow-growing variety, with well-developed connective tissue and thick-walled blood vessels, hemorrhage may not occur and the only early symptom may be that of nasal obstruction. The growth may have the appearance of a simple nasal polyp, yet upon removing it, the hemorrhage may be excessive; and this should be suggestive of cancer. It hardly seems necessary to say that every specimen should be examined microscopically.

Unfortunately we see but few growths limited to the nose. I have encountered but one malignancy of the inferior turbinate limited to the turbinate. Unfortunately also the growth may originate from the lateral nasal wall, where it soon extends into the nasal accessory sinuses, either the ethmoid, the antrum, the sphenoid, or the frontal. The nasal accessory sinuses then can be the site of malignant disease, either primary within the sinus or by extension from surrounding structures. We see it involved by extension from a lesion of the alveolus, of the hard palate, of the lateral nasal wall, or by an infiltrating new growth of the eyelids, of the external nose, or by metastasis from a distant primary lesion.

The symptoms of new growth of the maxillary sinus depend somewhat upon the location of the growth. Growths originating in the hard palate or the superior alveolus are characterized by *early swelling*. In the early phase, there is but little pain. With the invasion and destruction of the bone, the teeth may loosen and fall out, but it is a comparatively painless process. Extensive ulceration may develop with fistulization into the maxillary antrum and still be painless. A patient under my care states that the first symptom he noticed from a lesion starting in the hard palate was the fact that upon drinking, liquids came through his nose.

Lesions originating from the posterior, superior antral wall are characterized by a parathesia or an anaesthesia of the cheek of that side. They are oftentimes accompanied by pain referable to the teeth. It is not unusual for these patients to seek relief by repeated dental examinations and by the loss of one tooth after another in a vain effort to alleviate the discomfort. As infection is superimposed upon the original lesion, there may be early pain referred to the cheek; and puncture and lavage of the antrum has been carried out in many cases. With the increase in size of the new growth, there is extension into the nasal cavity with a mass which may block the entire nostril. Then, too, there is extension and destruction of the bones of the superior maxilla, with erosion of the anterior face of the maxillary antrum, or destruction of the rim of the orbit. Many patients do not seek medical advice until the growth has reached such a size that there is a mass over the cheek, or until the extension into the orbit has produced an exophthalmos.

New growths originating in the posterior part of the ethmoidal labyrinth may extend into the sphenoidal sinus; and if the optic nerve is involved, the first symptom is a diminution of vision on that side. Repeated hemorrhage should always be suggestive of cancer. The bleeding may be but a few drops, or a hemorrhage of such intensity that transfusions are necessary.

BIOPSY

I am an advocate of biopsy in every case, for our treatment depends upon the type of

tumor as shown by the microscopic examination. When in doubt, I am an advocate of an exploratory operation. A lateral rhinotomy, or an external canine fossa operation on the maxillary antrum, in my opinion, in a doubtful case is not only advisable but justifiable.

X-RAY

A unilateral mass obstructing a nasal cavity is suggestive of cancer. The usual x-ray picture of sinus cancer is that of the late stage, when destruction of bone has already taken place. Repeated x-ray examinations in every suspicious case should be the rule, if we are going to make the diagnosis early.

TREATMENT

There are but two methods of treatment of malignancy of the nose and nasal sinuses that have proved of value; namely *surgery*, and *irradiation*, or a combination of the two. If the biopsy shows the tumor to be an anaplastic new growth of the radio-sensitive type, radiation may be used alone. This can be in the form of either external irradiation, or by the use of radium. When there is superimposed infection, adequate drainage must be supplied. Occasionally interstitial radiation by the implantation of radium needles directly into the tumor has been tried. When the new growth is not of the anaplastic type, surgery followed by radiation, or the direct implantation of radium in the operative field, supplemented by external irradiation, is our treatment of choice.

OPERATION FOR NASAL LESIONS

Adequate exposure should be obtained for any operative procedure. New growths limited to the nasal cavity can be adequately exposed through a lateral rhinotomy. This incision starts opposite the inner canthus of the eye, and goes down the lateral wall of the nose and around the ala. The periosteum and soft parts are elevated from the bone, and the nasal cavity entered by the removal of the ascending process of the superior maxilla and the lateral nasal bone. By extending the incision upward, and the bone removal to include the lachrymal bone, access to the frontal sinus can be obtained. This exposure permits access to the

ethmoidal region, to the sphenoid, to all of the turbinates; and through this exposure the antrum can be explored. After removal of the new growth, the cavity is lined with vaseline gauze, packed with narrow-folded strips of gauze, in which radium in the form of either platinum or steel needles can be embedded. An attempt should be made to obtain at least a cm. of distance between the septum and the radium. The septum can be further protected by a shield of at least one m.m. of lead. The packing is brought out the nostril and the incision closed, unless it is desirable to leave it open for further inspection.

TUMORS OF THE SINUS

The surgical approach to tumors of the sinuses should depend upon the point of maximum involvement. If exophthalmos exists, and if it is questionable whether or not the orbit has been invaded, the ideal approach is through the orbit by an exenteration of the orbital contents. This approaches the maxillary antrum from above and the ethmoidal labyrinth from the side. By removing the floor of the orbit, the antrum can be explored; and by removing the lateral orbital wall, the ethmoidal labyrinth can be exenterated. It permits, too, an easy access to the frontal sinus.

When the lesion has originated in the superior alveolus, or from the hard palate with extension into the antrum, the ideal approach is from below by resection of the superior alveolus, including half or all of the hard palate. This approach permits access to all the accessory sinuses. It provides the best of drainage, but it handicaps the patient in that he must wear a dental prosthesis when eating. Lesions involving the ethmoidal labyrinth and the maxillary sinus without extension into the orbit, or without evident involvement of the hard palate, can be reached by any of the face-splitting operations.

In New England, under the influence of Barnes, we have been using the so-called Barnes incision, which is a modified Lagenbeck incision. This affords an excellent exposure, the incision is left open, permitting easy subsequent examinations of the operative field. It has the disadvantage, however, of leaving

the patient with a large hold in the face, which he must keep closed either by filling it with gauze, or with an artificial appliance. This is frequently objectionable, not only to the patient, but to their friends, so that they are unable to continue or to obtain employment. Another disadvantage of the Barnes incision is that it is exceedingly difficult to close by plastic surgery. I have had the unfortunate experience, in two cases, of seeing recurrences develop after plastic closure.

For the past eight years I have been using a modified Moure incision. This incision starts opposite the inner canthus of the eye, goes down the lateral wall of the nose, around the ala to the mid-line of the upper lip. It then goes straight down through the columella dividing the upper lip and with an incision through the buccal mucous membrane from the nasal spine to the last molar tooth. The entire cheek is turned back, exposing the superior maxilla. This exposure permits excellent inspection of the operative field, and permits the removal of the entire superior maxilla, if it is found to be necessary.

The incision is made with the cutting electric current, and all bleeders are stopped by electro-coagulation. The bone is removed with Rongeur forceps. The tumor is shelled from the antrum by a curet. Its removal is accompanied by a profuse hemorrhage, so that it should be removed rapidly. A large sponge soaked with hot saline is inserted into the cavity and this soon stops the bleeding. Ligation of the carotid artery has been advocated to control the hemorrhage and to diminish the blood supply of the tumor. I have not found it necessary to ligate the carotid artery in any case. DaCosta quotes fifty-six different anastomoses of the carotid artery, so that the effects of ligation of the carotid artery last but eight to ten days.

The ideal removal of any cancerous growth is by its removal through normal tissue. This is absolutely impossible in a region such as the nasal sinuses. Here the removal amounts to a curettage. The operation is ideal for disseminating the growth and producing either distant metastasis or local recurrences. For that reason, the entire operative cavity should

be desiccated with the coagulating current. For this reason too, I have advocated the local insertion of radium to destroy any scattered tumor cells. The orbit is protected with a shield of one m.m. of lead, the cavity lined with vaseline gauze, gauze packing is inserted, and the radium placed within the gauze packing so that there is at least one c.m. of gauze to act as protection. This gauze is brought out and partly through the buccal incision. The musculature of the lip is sutured with buried cat-gut sutures, taking care that the vermilion border of the lip is approximated exactly. The skin edges are then closed with dermal sutures. Depending upon the sensitivity of the tumor, the radium is left in place for a total dosage of 2000 to 4000 mg. hours. At the end of the desired time, under evipal anesthesia, the packing is removed through the buccal incision. In the after-treatment, care must be taken that the buccal incision does not close. This can be kept open by an obturator made of dental compound.

I am greatly indebted to Ohngren for the suggestion that the odor following this opera-

tion can be greatly alleviated by the use of a potassium permanganate spray.

Exophthalmos due to radiation reaction occasionally occurs. It is exceedingly painful, and plastic procedure on the lids to preserve the cornea have been of no avail. This reaction may take place early, or may be delayed as long as six months to one year after radiation. It is a trying situation as one must think of orbital extension or recurrence within the orbit. Orbital exenteration may be necessary, not only to relieve the pain, but to make certain that extension of the disease has not taken place. Studies of five such cases show the pathology to be that of edema and fibrosis.

The after-care consists of keeping the cavity clean. The patient can use a nasal irrigation at home with frequent applications of potassium permanganate spray—1-10,000. The discharge ceases in about two to three months. By keeping the buccal incision open, inspection of the operative cavity can be thoroughly made.

This operative procedure of primary closure of the face incision leaves the patient with a minimum of deformity, and permits the social and business life of the patient to continue without embarrassment.

PROGRESS IN OPHTHALMOLOGY

By ANDREW RADOS, M.D., Newark, N. J.

Read before the American-Hungarian Medical Association of New York, January 10, 1938.

Any ophthalmologist necessarily would welcome the opportunity to talk about the progress made in the field of ophthalmology before a large group of physicians representing the various fields of medical practice. The reasons are manifold; our special knowledge increased enormously in the past two or three decades; the field was partly enriched by facts of pure scientific value and by detail questions less important for workers without the specialty. But this concerted effort yielded new discoveries of unmistakable diagnostic and therapeutic value, and since many entities in our field are only the local manifestations of constitutional disorders, these are important enough to be

brought before a general assembly of physicians. It would be useless reiteration to mention the part played by the eye as an important factor in tuberculosis, nephritis, diabetes, multiple sclerosis, and other systemic diseases, neoplasm of the brain, hypertension, etc. These are but a few of the countless examples.

The field is too wide and complex to discuss such a topic intelligently in a single evening. Therefore, some phases will be treated only cursorily, and our immediate attention will be focused upon the most outstanding ideas requiring a survey of the field into which the reading of the man-in-general-practice may not lead him.

DIAGNOSTIC METHODS

The Tonometer.—The eye-specialist of the present could hardly imagine that in the early days of my training the tonometer was an instrument in the realm of dreams. How many mistakes we necessarily made in taking the pressure without any instrument of precision, but just by digital palpation! In the past twenty-five years, the Schiotz tonometer became an indispensable friend to the ophthalmologist.

The Ophthalmoscope.—A similar contribution of importance is the application of electric power in our hand ophthalmoscope. From the standpoint of the man-in-general-practice, nothing is of greater practical importance. The ophthalmoscope, constructed by Helmholtz, became, in the hands of von Graefe and his school, a medium through which a new world of scientific facts was unfolded. However, this new and interesting world opened its gates only to a few chosen ones. To familiarize oneself with the use of the ophthalmoscope,—the direct and indirect application,—was a rather hard and strenuous study, taking many months of trial and disappointment before the efforts were rewarded with success. The electric ophthalmoscope, which makes the observation of the eye-ground so infinitely easier, is, next to the stethoscope, an integral part of the physician's handbag. This small innovation opened the eye-grounds to the large masses of medical practitioners and became common knowledge to all.

The Nordenson Camera.—As a specialist, I would not be satisfied only with the electric variety of hand ophthalmoscope, but the later years, especially the work of Gullstrand, gave us the binocular and reflex-less instrument for more accurate observation. I will go only one step further and bring to your attention the development of the Nordenson camera for photography of the eye-ground; for we all appreciate the importance of being able by objective means to learn the extent of the pathological changes of the eye-grounds for future comparison and study. The significance of inspection of the posterior part of the eyes with the help of the newer instruments is self-evident.

The Slitlamp.—Improvements of no less significance in the observation and study of the

anterior segment of the eye have also been developed. It is to Gullstrand's genius that we owe the evolving of the *slitlamp* which, in combination with the modified Czapsky corneal microscope (through the endeavor of Henker of the Zeiss Works), gave us an instrument almost as revolutionary in its effects as the creation of the ophthalmoscope itself. The slitlamp gave ophthalmologists not only an instrument of much higher magnifying power, but created the possibility of examining the living tissues of the eye in an optical section. The combination of the two above-mentioned facts enabled us to see changes formerly invisible even through the microscope, as many delicate tissues suffer changes or are distorted through the necessary fixation. Here modern science created a medium which enables us to see the movement of the blood corpuscles, by employment of vital staining to study the finest nerve endings in the living cornea; to follow the movements of the individual cells within the anterior chamber; to open up new chapters in our knowledge about principal pathological and congenital changes in the lens; to study the sutures of the lens; and to inspect the delicate fibers of the vitreous formerly closed to the inspecting eye. The slitlamp opened up a new field to ophthalmology just as the discovery of the condensor lens of the microscope by Abbe practically made modern bacteriology and pathology possible.

The Ophthalmo-dynamometer.—Our diagnostic equipment was further enriched by the ophthalmo-dynamometer, a device enabling us to determine the blood pressure within the retinal vessels. The pioneering work was mainly done by French authors. The constant use of the instrument brought about various improvements and modifications. It is of distinct value in determining the intraarterial pressure in the retinal vessels with and without combination with hypertension in general, its relation to increased intracranial pressure, and its significance in diabetes and nephritis, especially since many observers are studying the possibility of diabetic retinal alterations due to vascular changes.

Ophthalmoscopy itself was greatly broadened through the introduction of red-free light by Vogt and his pupils. The original form,

the *eryoviridin solution*, was, in course of time, replaced by more suitable filters based on the same principle, which, in turn, made the method more applicable and handy. The formerly invisible vesicular changes in the macula were brought under observation, and exact localization and differentiation between retinal and choroideal bleedings, etc., were made possible.

X-Ray.—The diagnostic improvements mentioned above belong strictly to ophthalmology, but ophthalmologists appropriated for their own purposes the advances made in other fields of medicine; and so the diagnostic strides made in x-ray technic are employed to great advantage in the accurate localization of foreign substances within the eye-ball, and in visualizing fractures of the optic canal, structures of the tear-ducts, ectasias of the tear-sac, calcareous degeneration of retinal gliomas, calcification of the posterior part of the globe in shrinking eyes, etc.

CLINICAL DIAGNOSIS

The improved methods of observation, and the accumulation of new facts and knowledge of the eye have necessarily made a deep imprint on clinical diagnosis. Through the efforts of Schüller-Christian a new clinical entity consisting of exophthalmus, diabetes insipidus, and geographic-map skull became known. Although this entity, prior to Schüller and Christian, was described by Hand, only the exact laboratory work-up of the cases taught us that lipid masses deposited in the bone of the skull are chiefly responsible for the formation of granulation tissue extremely poor in cells.

In 1922, Biedl described the syndrome known as the Bardet-Lawrence-Biedl syndrome, consisting of pigment degeneration of the retina, dystrophia adiposita genitalis, deaf-muteness, polydactyly, and disturbance of intelligence (first reported in 1866 by Lawrence and Moon). The Marfan syndrome (arachnodactyly and dislocation of lens) was more than surprising. It showed clearly that a change such as ectopia of the lens considered as a purely local change of the eye, is only a part of a general systemic disorder. Similarly, we learned that the angioid streaks are connected with pseudoxanthoma elasticum of the skin. In-

cidentally, the heterochromia iridum, according to Passow, does not belong in the group of local changes either. He described generalized changes as disproportionate pigmentation, marked differences in the size of the breasts which he relegated to changes in the medulla belonging to the group of microsyringomyelia. The arachnodactyly and status disraphicus are, according to Passow, of similar nature, but possibly of different topographical localization. The picture of juvenile periphlebitis of the retina, which, through the work of Axenfeld and Stock seemed to be firmly entrenched in the tuberculous group, became the object of new study in the hand of Marchesani, who made efforts to prove its connection with the throamboangiitis obliterans (Buerger)—in my opinion, still subject to question. It is true that the tuberculous nature of periphlebitis cannot be established in all cases beyond reasonable doubt; nevertheless those instances are usually in young individuals not manifesting any changes in the extremities, and not middle-aged, males in the majority of the cases. The classification of these as thromboangiitis obliterans cannot be considered as fully proven.

To the group of eye symptoms connected with general manifestations belongs the Sjogren syndrome of Keratoconjunctivitis sicca, characterized by increased rate of sedimentation, lymphocytosis in the majority of cases, occasional eosinophilia, and anemia, subfebrile temperature, atrophy of conjunctival epithelium and tear gland, and sclerosis of the glands of the mouth, larynx, and pharynx. The syndrome is infectious, possibly endogeneous in origin, causing decreased secretion of the glands. The febris uveoparotidica (Heerfordt) is well established. The Harada disease (low-grade posterior uveitis with detachment of the retina) probably represents an infection of the eye starting with headaches and general symptoms of the encephalitis group. The angiomatosis retinae originally described by von Hippel is classified as the von Hippel-Lindau disease, being connected with angiomatous cysts of the cerebellum and cyst formation in the pancreas.

Argyll-Robertson Phenomenon—In the realm of one of the best-known and defined ocular symptoms, the Argyll-Robertson phenomenon,

which we are accustomed to designate as a positive sign of locomotor ataxia (ignoring rare cases of brain tumors), few new observations lead to the establishment of pupillotomy or Adie's disease. Accurate observations helped to establish the points of differentiation. The pupillotomy is usually unilateral, the affected pupil being larger and slightly oval in shape, the near reaction is not absent but extremely slow, and complete miosis is present, the following dilatation is still slower. The extreme slowness of reaction causes an apparent lack of light reaction. The pharmacologic reactions of the affected pupil are normal. This reaction is not luetic, and may occur in encephalitis, migrain, alcoholism, diphtheria, herpes zoster, myotonia congenita, and progressive muscular atrophy.

From the standpoint of the general practitioner, the hyptonia of the eyes in diabetic coma, described by Heine, is of utmost importance, especially in the differentiation of various conditions (coma diabeticum, uraemia, eclampsia) and optic atrophy substantiated by calcification of the internal carotis, the latter furnishing a plausible explanation of the optic atrophy in elderly individuals. The recognition of optic atrophy due to chiasmlarachnoiditis is of similar value.

CONJUNCTIVAL TULAREMIA

The exact laboratory research led to the classifying of the so-called Parinaud disease formerly considered as bovine tuberculosis of the conjunctiva, later identified by von Herrenschiwand as an infection due to *Bacillus tuberculosis rodentium*. The works of the American authors on tularaemia (McCoy and Chapin, 1911) gave impetus to the discovery of the fact that the infection is the oculoglandular form of infection with *Bacterium tularense*. The positive agglutination tests were very helpful, in subsequent cases, in the establishment of the diagnosis. The studies were followed up not only in this country, but similar findings were produced in the various European institutions; and the infection was traced to individuals handling infected hares and rabbits. The most outstanding fact in this field was that von Herrenschiwand pointed out the similarity of bacterium tularense to bacillus

tuberculosis rodentium as far as morphologic appearance was concerned; and with the help of the agglutination, considered the disease as oculoglandular tularemia.

MACULAR DEGENERATION

The classification of the disciform degeneration of the macular region (Junius-Kuhnt) has been achieved, and demonstrated that the initial changes are in the lamina vitrea (irregularity of staining), unevenness of the choriocapillaris with accumulation of cellular elements, thickening of the intermediar layer caused by the appearance of mesodermal elements and vessels, newly formed elastic fibers, proliferation of pigment epithelium, and formation of adhesions between retina and pathologically changed vitrea. The unilateral exophthalmus caused by meningioma of the lesser wing of the pterygoid is worthy of mention. We should also mention the positive findings of leptothrix by Verhoeff.

VITAMINE DISORDERS

The application of the principles of allergy led to differentiation of certain forms of conjunctivitis and edemas of the lids (angioneurotic edemas). The study of avitaminosis brought out the fact that the lack of vitamin A produces keratomalacia, xerophthalmus, and hemeralopia; and the lack of vitamin C, retinitis, vitreous bleedings, and lens opacities. Vitamin B seems to be of lesser importance, though corneal and optic changes in beri-beri are due to lack of vitamin B₁ (antineuritic factor); and retrobulbar neuritis and retinal changes in pellagra are caused by deficiency of B₂ (antidermatitic factor). Hemeralopia shows without any doubt, the importance of vitamin A in the metabolism of the visual purple.

But the most important interrelations were obtained through experimental production of cataracts through radiant energy, naphthalene, and allied poisons (i. e., dinitrophenol), tetany, and parathyroid deficiency. The excess of calcium in the cataractous lenses suggest in these conditions a definite relationship with the calcium metabolism of the animals. According to Adams, in senile cataract the potassium content practically disappears, and the calcium increases even to as much as eight times the normal amount. Bourne and Adams found the

blood calcium unchanged in rabbits by prolonged naphthalene feeding; yet they showed conclusively the blood calcium as the determining factor; for oat and cabbage diet prevents naphthalene cataract and causes high blood calcium. On the other hand, bran and carrots lead to naphthalene cataract associated with low-level blood calcium. The lactose and galactose cataracts of Yudkin and Arnold may be similarly explained.

FOCAL INFECTIONS

The importance of focal infections in causing inflammatory changes in different parts of the eyes are too well known to need detailed discussion. The overenthusiasm of the early period gave place to a more mature consideration of this field.

THERAPEUTIC ACHIEVEMENTS

It is, indeed, fascinating to continue with the diagnostic achievements of our special work, but in order to render a more or less complete picture, we shall now turn to the less interesting but more practical *therapeutic achievements*.

Telescopic Lenses.—In discussing this phase of ophthalmologic advance, I first want to point out the creation of the so-called telescopic and contact lenses. The telescopic lenses are, in principle, the reduced form of the opera glass, very beneficial in high degree of myopia, or in cases where the visual acuity is greatly diminished. They can be constructed equally well for distant as for near vision. Many an individual formerly incapacitated for reading rediscovered this pleasure through the help of telescopic vision.

Contact Lens.—Much more publicity is enjoyed by the contact lenses. Their history begins with Frick, but as with many other discoveries, for a while they remained in oblivion. Originally they were constructed for use in cases of conical cornea, where the abnormal curvature of the cornea caused a greatly diminished vision, and where the only possibility of correction was offered by the hyperbolic lenses of Raehlman,—and these, to say the least, were very far from satisfactory.

The first practical contact glasses were the *blown* glasses by Muller, who is well known

all over Europe for his artificial eyes. They were later followed by the *ground* variety from the Zeiss factory. The Zeiss contact lenses were a marked advance, inasmuch as they produced contact glasses of various diameters; and in the later years, further improvement was achieved by adding the individually necessary optical correction to the contact glass. These improvements are responsible for their increased popularity. The contact glass originally devised for conical cornea found a rather wide field in the correction of myopias, hypermetropias, and aphakias.

Contact lenses are in increasing demand, which is not surprising when we consider that individuals in public life or on the stage have found the means for discarding their thick and ugly correcting lenses, and are now enabled to appear before the public without conspicuous correction. The drawbacks, of course, are the price, which is rather high for the ordinary individual, especially if we consider not only the original investment but their extreme fragility and the ease with which they break. Some individuals have more, others less difficulty in getting used to wearing the lens. Some can wear it without any irritation at all; others cannot wear it for more than a short period at any one time.

Dallos applied a new principle in constructing his contact glasses. The older ones are separated from the cornea by a fluid layer and rest on the limbus and sclera. Dallos eliminated both. He takes an impression of the eye (Negocoll-Hominit method) and his contact glasses are worn without any irritation, resting on the cornea proper. There can be no question that the application of the contact glasses is the solution of the future, especially if the present price will be materially reduced. The superiority of the contact lenses lies in the fact that they give a retinal image of normal size and better visual acuity than can be obtained by ordinary correcting lenses; and also a full field of vision.

Foreign Protein Therapy.—In the treatment of acute inflammatory conditions of the eye, one of the most beneficial is the non-specific foreign protein therapy. The early beginnings in this work were the efforts in ophthalmo-

gonorrhea with autogenous vaccine, later with typhoid vaccine. It is to Muller's credit that milk injections were introduced in ophthalmology. The most brilliant results were obtained, especially in gonorrheal infection of the conjunctiva, and acute iridocyclitis. Weichardt thought this was due to protoplasma activation, thus explaining their favorable reaction. We know that the most outstanding symptom of the ensuing shock is the fever and leukocytosis, with the predominance of the mononuclear elements accompanied by an increase of cell permeability; due to the latter, the circulating antibodies penetrate the cells more readily. The original milk (boiled in a water-bath) was replaced by Aolan, Endolac, Lactigen, Omnadin, and numerous other proprietary preparations. I have to admit that I still prefer to use the simple whole milk for intramuscular injections, and typhoid vaccine for the intravenous ones. The latter causes a fairly strong reaction, especially when given first an initial small dose, followed by a somewhat larger one within the ensuing two hours; and so, in ocular disturbances, foreign protein therapy became one of the most valuable therapeutic additions.

X-RAY AND RADIUM

An increased field for the application of x-ray and radium in ocular diseases opened up in the last few years, and the field is constantly widening. About thirty years ago, Birch-Hirschfeld showed that x-ray exposure may result in cataract formation, and in degeneration of the ganglion cells of the retina. In the following years, we hardly find anything in the literature about the application of x-ray in ocular disease until Rados and Schintz reopened the question with new experiments. Since then we have learned from many observations that the Roentgen and radium may be applied to the eye only with the utmost caution, that the formation of a posterior cortical cataract occurs usually between one and three years following exposure. But, conversely, it was also shown that with proper care it may be advantageously applied, not only to tumors of the lid, orbita, and conjunctiva, but also in the treatment of chronic blepharitis, corneal ulcers, dextritic and sclerosing keratitis, rosacea

of the cornea, tuberculous iridocyclitis, and lymphomatous changes.

Since the Coutard technic was developed in malignancy of the upper respiratory tract, there is a revival of the treatment of retinal gliomas, which previously was given up as hopeless by Axenfeld himself, who, it must be remembered, was the inaugurator of this therapy. The latter question is more or less in the experimental stage as yet; particularly when we bear in mind the not too infrequent spontaneous healings. The result can be judged only in the future. In view of the highly malignant nature of the retinal gliomas (which are of much smaller cellular elements than the gliomas of the brain), I still consider the removal of the primary eye as the safest procedure, and only in instances where the second eye is affected would I entertain the idea of radiation treatment.

I am opposed to radium treatment of *vernal conjunctivitis*, the etiology of which is still unknown (there is a possibility of allergic or endocrine basis) and which, in the opinion of a few, gives a definite indication for radium therapy. In my experiences, I have never seen any beneficial effect from radium in cases of vernalis except in those where it was given near the puberty period when the vast majority are spontaneously relieved of the disturbing symptoms anyhow. On the other hand, in the course of years, I had to see old patients of mine (who became tired of conservative handling were advised by other consultants to try radium treatment which was given by internationally known radiologists) return with bilateral cataracts, a decidedly poor exchange for the vernal conjunctivitis which causes only subjective symptoms of itching, and almost never causes complications of the eye-ball itself.

A very useful field of application of the x-ray is that of absolute and degenerative *glaucoma*, where, due to the atrophy of the ciliary epithelium produced through radiation, a lowering of the intraocular pressure should be secured.

MISCELLANEOUS PROCEDURES

For the relief of pain in degenerative glaucoma, the use of retrobulbar alcohol injections

proposed by Grueter should be mentioned. By availing ourselves of this method, many eyes which formerly had to be removed or had to undergo the more complicated neurectomy optico-ciliaris, can be saved.

Alcohol injections are also successfully employed in high degrees of blepharospasmus. The treatment of superficial corneal ulcers due to pneumococci are highly benefitted by the ethyl-hydrocupreine (optochine) of Morgenroth; and corneal herpes, by touching with iodine. In the treatment of trachoma, the trachoid of Brecher must be considered of importance. From the drugs producing vasodilatation, acetylcholin was introduced for various conditions to relieve the spasm of the vessels, but its efficacy is still questionable. The unilateral acute retrobulbar neuritis, previously considered rhinogen in the vast majority and therefore operated upon even with negative findings in the sinuses, has been found to be a frequent first symptom of multiple sclerosis. In methyl alcohol poisoning, repeated lumbar punctures proved to be of some therapeutic value.

Keratoplasty seems to have gained a wider field of application as more successful work is being reported. The tattooing of large corneal opacities for purely cosmetic reasons is no longer performed with lampblack or chinese ink, but an ingenuous chemical reaction is evolved through the application of gold or platinum chloride. The result is a much more uniform black spot without the frequent discomfort of iridocyclitis as sequel to such procedure.

In the wake of the trend of sympathectomies in general medicine, Abadie, keeping step with this newer movement, performed a sympathectomy of the carotis in form of the Leriche operation for optic atrophy in 1920. The technic has since been modified by Magitot; Royce extirpated the upper ganglion; de Takats and Grifford performed the extirpation of the upper ganglion with sympathectomy of the internal carotis. The operations were performed mainly for relief of retinitis pigmentosa. The results were rather meager, no definite improvement in the fields of vision or in visual acuity resulted. Considering the seriousness of such a surgical step and the possible dangers,

the operation is not warranted, and I readily join the authors who advocate discontinuance of the operation. Scepticism also seems justified in the treatment of retinitis pigmentosa by female gonadic extracts introduced by Wibaut, which, even theoretically, has no basis not only lack of experimental evidence, since pigment degeneration is, in most of the cases, not a sex-linked disease at all, but rather in the majority of instances is inherited recessively and only rarely has been traced to dominant inheritance.

Ophthalmology necessarily gave warning in the administration of dinitrophenol, a drug widely exploited for reducing, as more and more cases of cataracts were observed after the ingestion of this dangerous drug.

Having gone over the general outline, I want to discuss in detail a few problems in which the strides of progress have been the greatest, and the knowledge of which is most useful to the practitioner in the general field of medicine.

GLAUCOMA

The fight against glaucoma is synonymous with the fight against preventable blindness. The study of statistics of blindness teaches us that up to the present, a large proportion of the community of the blind lost their sight through glaucoma, and, therefore, had the proper diagnosis and treatment been instituted, the percentage from this fruitful source could have been reduced. It is customary to judge the degree of civilization of nations and races according to the pro-capita use of soap. It would be more appropriate to use the yardstick of blindness caused by glaucoma.

No epoch-making progress can be registered in the study of the etiology of glaucoma, which is necessarily connected with our knowledge of the intraocular fluid contents. The basis of the latter is still the filtration theory of Leber. Excellent works have been written trying to solve the contradictory facts. Some authors have brought convincing evidence against the true secretion based on the difference of intercapillary and intraocular pressure; others emphasized the importance of osmotic interchange, and dialysis was substituted for filtration. The problems are extremely complicated. We must keep in mind the differences between the

human and animal eyes; also, that there is a marked difference between first and second aqueous, the latter being closer to filtration. At any rate, filtration and dialysation do not suffice to explain all the happenings in glaucoma.

Though epoch-making progress cannot be noted in the etiology of glaucoma, the progress in its diagnosis and treatment is certainly marked. Important in the early diagnosis of glaucoma is the recognition of the fact that merely taking the pressure is insufficient to eliminate any suspicion of a possible increased tension, since the pressure is known to vary considerably during twenty-four hours. The daily curve of intraocular pressure shows both a lowest and highest point. The peak usually occurs after midnight, during the early morning hours. The variation is marked even under normal circumstances, but becomes greater under pathological conditions. Keeping the daily record of a suspected eye is one of the most reliable procedures in doubtful cases.

Other tests have been introduced to detect the early stages of increased pressure:

1. Through decrease in the elimination of the fluids (the dark-light test of Seidel), in glaucomatous eyes the difference may amount to 10-40 mm. This measure is effective only in the prodromal stage or with shallow chamber where pigmentary changes or peripheral synechias provoke a blockage of filtration (as mydriatics do).

2. General and local changes in the blood pressure, 0.2 grm. coffeinum natr.-sal. intravenously (Lohlein, Thiel), stasis in the region of jugular veins, deep position of the head; massage (Wegner) causes a decrease of the tension of 3-4 mm. in normal eyes, and no change in glaucomatous eyes.

3. The lid closure of Poos.

The old approach to the treatment of glaucoma consisted in the instillation of miotics (eserine, pilocarpine) based on the teaching that glaucoma represents a blockage of the angle of the chamber, and, therefore, in logical sequence, liberation through miotics. Recent experimental data, however, brought out the facts that numerous other factors, such as the capillary permeability, the nervous control of vascular changes, the osmotic pressure of the

blood and its chemical composition, the hormonal influences, etc., are to be considered. Accordingly, new remedies were introduced, and the most useful proved to be epinephrin and its derivatives, especially in compensated cases of glaucoma and in iritis glaucomatosa, a picture described by one of my early teachers, Professor William Goldzieher. The adrenalin is employed in the form of instillation, subconjunctival injection, or as a small cotton pledget placed in the upper fornix. The laevoglauconan of Hamburger is 1 to 50 solution of adrenalin of instillation. Histamin (aminglauconan) was introduced in acute glaucoma, but it produces rather vehement symptoms such as swelling and redness of the conjunctiva, irritation of the iris, and even hypopion. Doryl of Vehlagen, on the other hand, is followed by almost no deleterious effects. The use of hypertonic solutions (ten per cent sodium chloride, two per cent glucose) produces a hypertonicity of blood plasma with a marked decrease of blood and intraocular pressure, and has proved itself very valuable for the transitory reduction of high intraocular pressure preceeding operations.

Glaucoma, from the standpoint of treatment, is strictly a surgical problem. Experience has taught us that the operated cases are far better off than those treated palliatively. In the good old days, the only operative procedure consisted of the classical iridectomy of von Graefe, an operation reserved now only for the acute cases in which the results are usually excellent. The shortcomings of iridectomy in chronic and simple glaucoma caused dissatisfaction and engendered the belief that the operative treatment of glaucoma is inadequate. Unfortunate cases led the operators to adopt newer measures for the control of the disease and reasonable prevention from further deterioration. Among the more recent types of operations, the iridectomy ab externo (Fuchs, Elschnig, Salzman), the cyclodialysis (Heine), the sclerectomy (Lagrange), the iridencleisis (Holth), the iridotaxis, and sclero-corneal trephine (Elliot), are to be mentioned. Each type of operation has its advocates, some of the operators preferring to perform one of the filtering type of operation, others employing a type depending upon visual

acuity, field of vision, type of glaucoma; and last but not least, the unsuccessful operation already performed on the same eye. Doubtlessly, the newer glaucoma operations must be considered in the light of decided step forward.

Numerous eyes which previously would have had to share the misfortune of their blind brothers have been saved. For many reasons I personally like to do either the Elliot trephine, or cyclodialysis, and thereby enjoy the satisfaction of seeing these patients return after a long lapse of years with vision that is still useful.

DETACHMENT OF THE RETINA

To illustrate the importance of surgical treatment of retinal detachment, we must remember that 20 per cent of the adult blind lost their vision because of detachment; that spontaneous reattachment was almost unique and the cases were given up as hopeless; and that the medical treatment, so far, was incapable of coping with the disease. The discovery of the importance of retinal holes and tears, and the searing of them, is to be credited to Gonin, who initiated a new chapter in operative treatment of retinal detachment; and we owe it to his genius that a great majority of these formerly hopelessly blind are able to regain their vision. The difficulty is rather in the examination and its accurate performance rather than in the technic of the operation itself. Too often highly myopic eyes, clouded vitreous, or lens opacities, prevent us from accurate observation and localization of the possible tear or tears. In such cases we must be satisfied with large barrages instead of closure of the tear, which makes the prognosis so much poorer. The accurate localization of tears is difficult but indispensable in order to avoid extensive operation and the sacrifice of valuable retinal areas. Careful ophthalmoscopy must be accompanied by no less careful studies of the field, if the visual acuity is sufficient. The early cases give a much better prognosis. In the late ones, the possibility of complete reattachment is considerably dependent upon the secondary proliferative changes within the subretinal space.

Gonin applied the cautery, which subsequently was replaced by multiple trephining

and touching up of scleral openings with potassium hydroxyde (Guist). This method was practiced only in exceptional cases and has given place to the coagulation by diathermy in form of surface or penetrating coagulation (Weve, Safar) or katholysis (Vogt, von Szily). Cautery and caustics have practically been abandoned because of the danger of post-operative haemorrhage. The majority of operators seem to avail themselves of diathermy as the procedure of choice. Diathermy appears to be better tolerated by the eye tissues, untoward results and complications are more remote, and the coagulating points produce an adhesive chorioretinitis resulting in firm adhesion between choroidea, retina, and sclera, and fixation of the retina. The ideal result depends upon the closure of the tear. If this cannot be achieved (separation of the ora serrata), a large barrage has to be established. The prolonged and sometimes fatiguing ophthalmoscopic examination, the carefully planned and ophthalmoscopically controlled operations are producing very encouraging and satisfactory results. Before leaving this topic, I want to emphasize once more the importance of early surgical interference when the prospect of replacement is as high as 75 per cent.

CATARACT

The so-called medical treatment of cataract can be disposed of easily; the various remedies including dionin, iodides, etc., applied locally or generally, or the recently revived lens antigen treatment constitute, to say the least, a well-anticipated disappointment. ✓

Cataract or glaucoma are matters for the surgeon, and the later years have merely given a modern aspect to the old, old problem. Many facts of yesterday seem to be just as antiquated as the old approach of reclination of the cataractous lens, which was so masterfully depicted in Rembrandt's immortal picture "Tobias Heals His Blind Father".

About fifty years ago one of the old masters of ophthalmology, Pagenstecher, tried to introduce intracapsular extraction of the lens and performed some 200 operations with this technic. Somehow it had no followers; surgeons employed the combined extraction method of

von Graefe to their complete satisfaction. It is to the credit of Török to have introduced the modern intracapsular extraction which, in turn, was modified by Knapp and Elschmig and became the modern operations with better results from the standpoint of vision, shortened period of convalescence, and less postoperative complications (iridocyclitis, etc.) and eliminating entirely the necessity of dissection of the secondary cataract. The intracapsular extraction became very popular in spite of the dangers of a larger percentage of vitreous loss and subluxation of the lens due to premature rupture of the capsule which makes the operation more complicated and dangerous. The possibility of late retinal detachment due to the loss of the Zonula support and vitreous prolaps into the anterior chamber induced Axenfeld to sound a warning; and experienced operators like Heine, and more recently, Meller, declared themselves in favor of the old extracapsular operation. The newer views of Meller are rather significant, as he was an early advocate of the intracapsular method and practiced it extensively. The older means of intracapsular extraction, like the phakoerisis of Barraquer, are now completely abandoned, and the operation of Török, Knapp, and Elschmig has become the technic of the present.

The intracapsular method seems to have increasing field of usefulness, and the modern approach has been made possible only through improved methods of anesthesia. The complete relaxation of the patient, the disappearance of fear and mental anxiety, is best achieved by

rectal administration of avertin or the intravenous use of sodium evipan. The extensive use of one or the other of the two methods marks real progress. But even the surgeon, who, for various reasons, is not willing to adopt the aforementioned anesthesia, has an aid in the refined technic in the retrobulbar novocaine injection producing insensitivity of the entire globe and extraocular muscles, and which has an added advantage in the ensuing hypotony. A further important adjuvant to local anesthesia is the elimination of the pressure of the lids on the globe through paralyzing the orbicular muscle by akinesia (van Lint), the novocaine being injected along the orbital margin close to the periostum, or the modification of O'Brien, the injection of the facial trunk at the crossing of mandibular articulation. The bridle suture of Elschmig and Blaskovich is of decided aid in eliminating movements of the eye during the operation.

This short résumé of a large and important subject is but a scanty attempt at outlining the vast material which has accumulated through countless ages of a specialty that, in some respects, is almost as old as history itself. At best, I have only skimmed the subject in order to bring out in broader relief the highlights of our progress in this field. I have spoken only of those milestones which are not only of purely ophthalmological interest, but of greatest significance and importance to the profession at large.

31 Lincoln Park

SALICYLATE POISONING—REPORT OF A CASE

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Read before the Orange Memorial Hospital Clinical Society, March 25, 1938. From the Pediatric Service.

With the present liberal use of salicylates, it is well to remember that poisoning from drugs of this group can occur. More palatable preparations of the drug are appearing in the form of chewing gum and lollipops, hence it is well to be watchful for accidental poisoning in children, in addition to therapeutic overdosage.

The following case will illustrate the salient features of salicylate poisoning:

A three-year-old Italian boy was admitted to the Pediatric Service at Orange Memorial Hospital on March 20, 1938, because of rapid breathing for one day. The child's previous health had been excellent. Four days before admission, he became irritable and feverish. He was seen by the family physician, who diagnosed the condition as tonsillitis.

tis, and prescribed a liquid medicine, which was taken during the next three days. The medicine was refilled without consulting the doctor. The fever continued with a diminishing intake of fluids, and the child began vomiting one day before entering the hospital. On the day of admission, rapid breathing was noted, and the attending physician then diagnosed the condition as pneumonia.

Examination in the hospital revealed a pale, thin Italian boy of three years with obvious air hunger. Respirations were deep and rapid, with the accessory muscles of breathing brought into play. The skin was dry and inelastic. His lips were a deep purple-red color, and the tongue was dry and furred. The throat and tonsils were acutely injected, and there was a sweet fruity odor to the breath. The left ear-drum was red and bulging. Coarse, moist râles were heard at both lung bases posteriorly, but the percussion note was resonant. Examination otherwise was not contributory.

Inasmuch as the parents spoke English poorly, the history as it appears had to be elicited later; and the nature of the drugs used could not be ascertained. The appearance of the child suggested an acidosis, due to diabetes mellitus or to drug ingestion. Urinalysis revealed a yellow precipitate with Benedict's solution, a three-plus acetone reaction with the sodium nitroprusside ring test, and a positive diacetic acid test with ferric chloride solution, but the characteristic Burgundy color did not disappear on boiling. This suggested the ingestion of a member of the salicyl group, but to be sure that the child was not suffering from diabetic acidosis, a sample of venous blood was secured for determination of the blood sugar and carbon-dioxide combining power. Pending the results of these tests, the child was given fifteen units of insulin subcutaneously and eight ounces of orange juice by mouth. Subsequently, it was found that the blood sugar was 81 milligrams per cent and the carbon-dioxide combining power of the blood was 23 volumes per cent. It then seemed likely that we were dealing with a drug acidosis.

During the next twelve hours, the child took and retained fifty ounces of sweetened fluids with marked improvement in the hyperpnea, although the carbon-dioxide combining power of the blood, twenty-four hours later, was still diminished to 32 volumes per cent. His temperature subsided in twenty-four hours, and he made an uneventful recovery. Other laboratory measures including blood Wassermann, Mantoux test, and chest roentgenogram were negative.

It was subsequently learned that during the four days prior to admission to the hospital, the child had taken approximately 200 grains of acetylsalicylic acid in liquid form, or six grains of the drug per pound of body weight.

Salicylate poisoning may arise from the ingestion of acetylsalicylic acid (aspirin), sodium salicylate, or methyl salicylate, and from the cutaneous inunction of methyl salicylate. The patients present vomiting, dehydration, ex-

treme thirst, profuse sweating, mental confusion, and most characteristically, rapid deep respiration of the Kussmaul type. At first, there is generally polyuria, but late in the course of severe cases, anuria with uremic manifestations develops. The urine reduces copper solutions, giving a false positive test for sugar. It also produces a strongly positive test for diacetic acid with ferric chloride solution, which may be shown to be false by the persistence of the purple color on boiling the urine. Acetone is generally present due to an associated ketosis from the vomiting, dehydration, and carbohydrate starvation. These urinary findings, coupled with the characteristically low carbon-dioxide combining power of the blood, suggest a diabetic acidosis, but the blood sugar will be found to be within normal limits.

Several reports of salicylate poisoning have appeared in the literature.¹ The most complete recent writing on the subject is that of Dodd et al.² They have shown experimentally, on man and animals, that salicylates act by increasing both the production of heat through increased metabolism, and the elimination of heat through vasodilation. Thus, defervescence is effected by evaporation of the body fluids in the form of perspiration. Since salicylates cause an increase in the production, as well as the elimination of body heat, it can be understood how a toxic individual, particularly a child, who refuses fluids, soon depletes the fluid reserves of the body. Perspiration is thereby diminished, with a further reduced ability to disperse body heat. This causes a rise in temperature, which further accelerates metabolism. In turn, ketosis and increased blood viscosity result. Because of the ketone acidosis, hyperventilation or hyperpnea is instituted, with the resultant low carbon-dioxide combining power of the blood. As a result of the diminished blood volume, kidney function is impaired. If this is sufficiently severe, anuria ensues with uremic manifestations.

Bearing in mind the mechanism of salicylate poisoning, treatment should be directed to the restoration of body fluids, and to the reduction of fever when present. Sweetened fluids should be given freely by mouth. If the patient is

unable to retain these, the parenteral administration of normal saline and ten per cent glucose solutions should be promptly given. The hypertonic solution of glucose stimulates renal secretion, and makes glucose available for the correction of the ketosis. Normal saline solu-

tion furnishes electrolytes lost through perspiration. If high fever is present, alcohol sponges, and exposure to an electric fan promotes evaporation from the skin, and thereby helps to reduce the fever.

143 Park Street

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THE MANAGEMENT OF MISSED ABORTION MATERNAL WELFARE ARTICLE NUMBER THIRTY-FOUR

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Read before the Section on Obstetrics and Gynecology of The Medical Society of New Jersey on May 18, 1938.

Without attempting a detailed, and probably controversial, discussion of the intricate endocrine processes which control all the phenomena of gestation, it may be stated that the retention of the impregnated ovum within the uterus, and its development, depend upon a proper balance of endocrine control. Similarly the expulsion of the gestation product at its maturity would appear to depend upon an evolution of such endocrine balance; whereas its expulsion either before or after the normal period of maturation depends upon some disturbance of that balance.

Inasmuch as it is extremely probable that the foetus, or placenta, or both, during the period of their normal development and function, contribute in some sense to the interplay of endocrinal influences, it is inevitable that the death of the conception product should seriously disturb the interaction of these substances, and lead directly to the expulsion of the product of conception from the uterus.

Such expulsion therefore would seem to be a consequence of the death of the foetus at

some stage of its development. The time relation, however, between the death of the foetus and its expulsion may vary within very wide limits. Such time variability is of course within certain limits physiologic, but it is apparent that wider variance may constitute a pathologic entity. We propose to call this entity of prolonged retention of the dead conception product in utero, in accordance with common practice, "Missed abortion". We will apply it to such prolonged retention without regard to the period of utero gestation to which the conception products has attained either at the time of foetal death, or of its expulsion.

To fix a time limit, however, which will separate physiologic variation from pathologic failure of the uterus to empty itself within a reasonable time, entails the selection of a purely arbitrary point. Because of the difficulty of determining surely the death of the foetus, and the necessity of basing such determination partly on comparison of repeated findings on physical examination in any particular case, Litzenberg has proposed, and many other writ-

ers have accepted an arbitrary limit of two months. We will use this limit for purposes of definition in this paper.

Also for the sake of clear understanding it is necessary to further limit the subject of discussion by definition, to those cases in which the whole conception product is thus pathologically retained. To admit any other type of case, such as incomplete abortion, in which portions of the conception product are not infrequently retained for long periods, even up to many months, would be to obscure our thought of the subject under consideration, and introduce indications which might not be valid for the strictly defined condition we are discussing.

To sum up our definition then, missed abortion is that condition in which the whole conception product is retained within the uterus for a period of not less than two months after the death of the foetus.

Only brief and incidental allusions will be made to the incidence, symptomatology and pathology of the condition, as it is desired to invite your attention particularly to its management.

Standard texts vary in their advice on this point. Thus Litzenberg says: "Once the diagnosis is made, the uterus should be emptied." Schumann, De Lee, and Titus make similar statements. But Peckman says: "The policy of watchful waiting is * * * persuade, and operative measures are used only when indicated by the physical or mental condition of the patient." Stander also agrees with this plan, and C. H. Davis agrees that treatment must be varied according to the symptoms and findings.

The reasons given by those who advise prompt, and sometimes radical interference, upon the establishment of the diagnosis, are:

1. That a wide variety of constitutional symptoms, most of which might appropriately be grouped under the general heading of malaise, depend upon toxic absorption from the dead foetus.
2. Infection is a not inconsiderable risk.
3. Missed abortion is frequently marked by degeneration of the uterine musculature with hyalinization of the vascular supply, constitut-

ing risk of hemorrhage greater than is usual in ordinary cases of abortion.

4. The uncertainty and fear engendered by a patient's knowledge of the abnormal course of her pregnancy may of itself determine serious psychologic or even psychiatric problems.

We propose to review experience in handling these cases as they have appeared in our own clinic during the past seven years, in an attempt to determine whether these fears of unusual risks in missed abortion are valid, and whether any determination can be made as to the relative advisability of conservative or radical treatment.

FREQUENCY

In relation to 31,303 live births, there appear in our files 63 cases diagnosed as missed abortion. Of these cases, 28 are eliminated because:

a. There was no demonstration of a complete conception product at the time of evacuation of the uterine contents. These, therefore, presumably constitute cases of unusually prolonged retention of portions of the conception products, and should be classed as *incomplete*, rather than as *missed* abortions.

b. Cases in which the time interval between the death of the foetus and expulsion of the conception product was too short to conform to the requirements of our definition already stated.

TABLE 1

Living births to March 31, 1938	31,303
Cases diagnosed missed abortion	63
Cases eliminated due to—	
a. Being really incomplete abortions.	
b. Insufficient time interval (less than eight weeks)	28
Leaving valid missed abortions	35
Incidence—	
One in 894 live births, or 0.11%.	

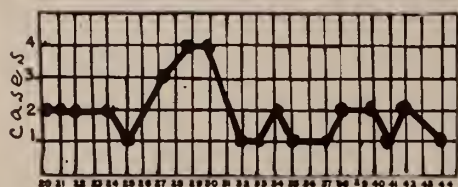
This leaves 35 cases validly included under our definition.

The final results of the 35 cases were:

Cured	34
Died	1
Mortality percentage, 2.86.	

AGE

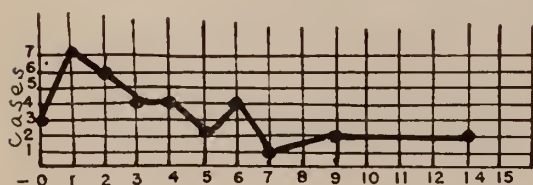
With reference to age, the distribution is fairly regular, except for a marked peak between ages 27 and 30.



Graph 1.—Age of mothers.

PARITY

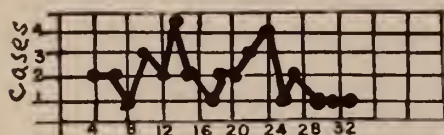
The record of parity shows a large proportion of the cases occurring in the second pregnancy, with a gradual falling off with increasing parity.



Graph 2.—Numerical order of pregnancies.

FETAL AGE

Estimation of the time at which death of the foetus occurs is exceedingly difficult. History is frequently indefinite because of the paucity

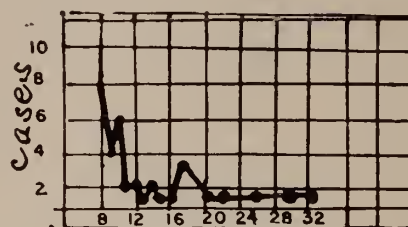


Graph 3.—Fetal age (in weeks) at death.

of symptoms at the time of foetal death. Besides, patients are often unreliable and contradictory in their statements.

Only occasionally have patients been under such close competent observation from the beginning of their pregnancies as to confirm history by careful, frequent, objective observation. There is frequently discrepancy as between the time of death indicated by the history, and the age of the foetus at death determined as closely as possible by pathological

examination of the extruded conception product. The apparent age at death as exhibited by the pathological characteristics of the extruded foetus may be invalidated by the regressive



Graph 4.—Interval between death of the fetus and its expulsion.

postpartum changes in the foetus prior to pathological examination.

In the cases under discussion, therefore, attempt has been made in each case, by careful comparison of all information furnished by history, objective findings, and pathological reports, to ascertain the probable period of death. It is realized, however, that the factors of error in such calculations are so great that not more than probable accuracy can be claimed for them.

To some extent, the same factors of unreliability of history, unless checked by competent observation, apply to estimations of the total elapsed time from the beginning of the pregnancy to the extrusion of the foetus. Such error is probably not so large, however, as in the matter of assessment of actual time of foetal death.

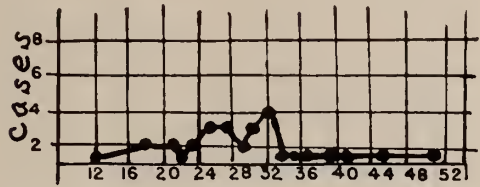
Graphs of the period at which death has occurred in this series shows that most of them are distributed between twelve and twenty-four weeks; with an irregular distribution beyond these limits in both directions, from a minimum four-week period to a maximum thirty-two-week period.

RETENTION OF FETUS AFTER DEATH

The interval between death of the foetus and its expulsion shows the highest incidence at the minimal allowable period of eight weeks, abrupt falling off thereafter to the twelfth week, and a fairly even distribution thence to the thirty-second week.

The total period elapsed between the begin-

ning and the termination of the pregnancy shows a definite peak at the thirty-second week.



Graph 5.—Total elapsed period until expulsion.

Comparison of these three graphs therefore shows that there is no correspondence between them. That is, there is no rule by which one may say that the earlier the foetus dies, for instance, the shorter time it will be retained in the uterus after death. Similarly no other rule of correspondence can be predicated upon comparison of these events. One of the earliest deaths was retained for one of the longest intervals before it was finally removed by operation.

It is, of course, realized that this whole series is so small as to make conclusions from any statistical standpoint absolutely valueless as a basis for statement of general trends.

Therefore, certain complications and miscellaneous data have been listed in detail as a matter of interest, rather than making any attempt at statistical grouping.

TABLE 2

Complications and Miscellaneous Data	Cases
Appendicitis, acute, with operation, 2 days before extrusion	1
Toxemia	7
Unclassified	2
Hypertensive	3
"One of these exhibited same type of toxemia in a subsequent pregnancy"	2
Septicemia, streptococcus hemolyticus, incurred prior to admission	1
Fall possible cause of fetal death	1
Encephalopathy with mental deficiency	1
Tuberculosis, pulmonary	1
Fifth similar experience with interval of 10 days to 3 months	1
"Present case, 8 weeks"	3

Twins of these, in one case the missed abortion was mummified, its twin "uniovular" was living and well at term.

Complications and Miscellaneous Data (Cont.)	Cases
Hydrocephalus	1
Fetus mummified, "including one noted above"	3
Fetus papyraceus	1
Fetus partly resorbed, "both not over 8-10 weeks"	2
Subsequent normal pregnancy	1
Severe upper respiratory infection at time of fetal death	1
Previous abortions of other types—	
1	5
2	4
3	1
4	1
6	2
Intraligamentous cyst of ovary	1
Two prior Cesarean sections	1
All white women except	2

Miscellaneous Data

Of especial interest in this listing is the incidence of toxemia in 20 per cent; of the occurrence of previous abortions in 37 per cent; the 11 per cent incidence of twins which would appear to be high in reference to all pregnancies. But as we have no comparable statistics for abortions in general, it is not known whether our incidence is higher than in other types of abortion.

It is *not* apparent that criminal induction was a very important factor in many of the cases in this series.

SYMPTOMATOLOGY

The general symptom picture was irregular, and not particularly characteristic. Those patients exhibiting toxemia showed in varying degree the subjective and objective evidence of their complicating condition. The majority of cases exhibited or gave a history of some irregular bleeding during the course of the pregnancy. This bleeding was rarely copious enough to be alarming, or to force management in reference thereto. In no case was there excessive or alarming hemorrhage following the extrusion of the conception product.

The Ascheim Zondek test was availed of in seven only of this series. It is not of very definite help in determining the fact of foetal death. Inasmuch as both chorion and decidua may continue to grow after foetal death, a positive A. Z. test is not proof of the death of the foetus. A negative test, however, in the presence of sure evidence of a previous living con-

ception product, is proof of foetal death. Only in this sense does this test aid in the determination of a diagnosis of missed abortion.

Speckman, Goldberger, and Frank have emphasized this fact. They state that estimation of female sex hormone in the blood is of much more definite help, but we had no opportunity of applying this test in our series.

MANAGEMENT

The different methods of management are exhibited in detail, and embrace nearly all methods commonly applicable to such cases. Spontaneous extrusion, with or without various methods of inducing such extrusion, occurred in 68.6 per cent of cases. Dilatation and curettage was done in 20 per cent of the cases.

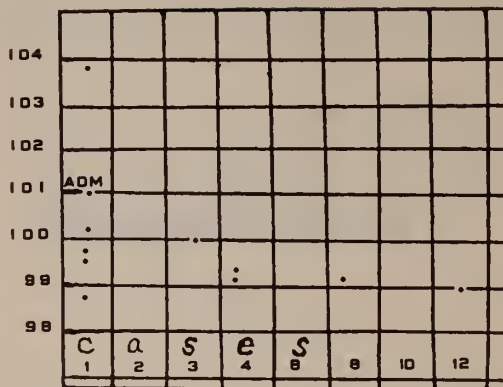
TABLE 3

	Cases
Spontaneous	16
Breech	2
Breech following bagging	1
Following medical induction	1
Following catheter induction	1
Following curettage 12 days	1
With sponge forceps removal of secundines	2
Total spontaneous	24—68.6%
Unsuccessful medical induction	1
Bagging	
Version	
Cesarean section	
Hysterectomy	1
Removal with sponge forceps	
Dilatation and curettage	7—20%
Vaginal hysterotomy and curettage	1
Digital removal of fetus and secundines	1

Management and Methods

MORBIDITY

The febrile morbidity was most astonishingly low, without reference to type of management. Temperatures were taken, according to our standard rules,—by rectum at four-hour intervals; and the morbidities recorded were arrived at by detailed scrutiny of the temperature graphs in each case. Morbidity was calculated on the national standard, i. e., temperatures of 100.4 F. in any two twenty-four-hour periods following delivery, exclusive of the day of delivery.



Graph 6.—Cases having temperatures above normal.

Mortality.—All cases except one recovered, a mortality rate of 2.86 per cent.

One case only required secondary admission and operation for metrorrhagia due to a retained portion of the conception products following spontaneous extrusion.

The single mortality in the series represents, I think, two most important factors of avoidable maternal mortality:

1. Patient's carelessness in recognition of the gravity of symptoms and neglect to seek treatment.

2. Error in judgment in management after coming under observation.

A brief synopsis of the fatal case is as follows:

History No. 30818—Forty years old, white, seven-gravida, with good prior labor history. She had her last menstrual period May 22, 1936. On July 16, 1936, she had an induced abortion, being then supposedly eight weeks' pregnant. She did not menstruate after this, but felt life in October, 1936, thus making it questionable whether the attempted abortion had been successful. She continued to feel life, and exhibited all the other signs of a progressive pregnancy until some time in March, 1937, at which time she had labor pains for two days, and foetal movement ceased. Patient continued to feel well, however. In the later part of May she lost her appetite, began to feel lethargic, and to have a foul vaginal discharge and foul breath.

On June 7th, 1937, she sought medical advice for the first time, and was referred to the hospital by her private doctor. Her temperature on admission was 100.6. It rose to 101, and then gradually subsided. There was no leucocytosis at this time, and patient felt well; there was a little vaginal spotting; the abdomen was not tender; the fundus was

about two finger-breadths below the ensiform; the uterus was hard; the foetus was in transverse presentation; the external os two fingers dilated, and the internal os, one finger; and the membranes were ruptured.

Shortly following her admission she had a medical induction without result. Two days after admission her temperature again began to rise and the writer counselled the insertion of a bag to dilate the cervix and expedite expulsion of the foetus. A bag was inserted on the sixth day following admission, but the bag in twenty-four hours' time had not excited labor nor produced much increase in cervical dilation. At this time the patient's temperature began to rise sharply and it was apparent that a serious septic invasion of the uterus had occurred. Thinking that it was becoming more and more urgently necessary to empty the infected content of the uterus, and recognizing the danger of abdominal delivery under such circumstances, the writer counselled gentle podalic version, contemplating further expectant treatment after the breech should have been brought into the cervix, in the hope that correction of the disadvantageous presentation and the presence of the breech in the cervix would stimulate to better advantage expulsion of the foetus.

A version was accordingly accomplished, but immediately following it the patient went abruptly into such severe shock as to make it evident that the manipulation had ruptured the uterus. Patient was therefore immediately transfused, and as promptly as possible laparotomy was performed. An extensive laceration was found extending through the cervix into the right broad ligament. Both broad ligaments were suffused with blood, and the uterus itself was extensively ecchymotic, but there was no free blood in the general peritoneal cavity. The foetus was removed by hysterotomy; and hysterectomy was completed as rapidly as possible. Further blood transfusion was carried out during the operative procedure. The patient died twenty minutes after completion of the operation.

Management of this case contemplated from the beginning the least radical interference possible under the circumstances of its progress from time to time. So, successive attempts were made by medical induction, bagging, and version to induce spontaneous emptying of the uterus. In the course of these attempts infection set in, later identified by culture from the cervix and uterus as due to hemolytic streptococcus. So rapid was this invasion that autopsy findings showed very extensive necrotizing involvement of the whole uterus. The version was attended by such accident as is inherent in this operation undertaken under difficulties, and death was directly consequent

upon the hemorrhage attending this accident. In retrospect, while the attempt to adhere as closely as possible to expectancy in the management might be defended, it is evident that deliberate radical operative emptying of the uterus with the removal of the organ if sufficiently degenerated to warrant that procedure would have given greater promise of success.

COMMENT

It had been hoped that by this review it might be possible to ascertain, by the results of varied management of these cases, which was the preferable tendency to follow in that management, as between radical interference as soon as a diagnosis is established, or complete expectancy in the assurance that nature is almost invariably capable of working out spontaneous termination. This we have been unable to do. If the fatal case detailed above, in which the outcome depended upon questionable judgment in management is eliminated, the whole series shows remarkably good results from a variety of management. It is perfectly apparent that, with the inclusion in the series of cases representing all periods of gestation, difference of management will properly apply to different periods of gestation. For instance, the dilatation and curettage applied to one-fifth of the cases is obviously suited only to those cases occurring relatively early in pregnancy; whereas more formidable surgical attack would have to be resorted to in the radical treatment of the later periods of gestation. Moreover, management will necessarily be predicated on the seriousness of particular symptoms exhibited, as for instance, hemorrhage.

It is, however, perhaps significant that spontaneous extrusion of the conception product did occur in almost 70 per cent of the cases in various stages of gestation. Moreover, the conservative management thus largely applied to the series did not result in the excessive hemorrhage or other serious sequelae, which are urged by some authors as an indication for radical interference.

In a group of patients largely comprised of clinic material, the serious factor of patient

and family psychology has not obtruded itself as importantly as it might do in private practice. This psychologic situation may in fact in some cases be the most difficult phase of the situation with which the attendant is called upon to cope, and may even in some instances necessitate a line of management looking to the prompt emptying of the uterus without reference to other indications.

CONCLUSION

The only conclusion that can be drawn from this brief study is that missed abortion is susceptible of spontaneous evolution in a distinct majority of cases, but that a variety of management may be indicated by the particular circumstances of the individual case and that the result of such variety of management judiciously applied may be uniformly good.

Acknowledgement is made to Dr. James R. Nealon for much help in preparation of data.

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A LESSON FROM A DEATH CERTIFICATE

NUMBER SIX

Patient nearly two months pregnant. At 8 p. m., had a severe low abdominal pain which radiated to the epigastrium. She gradually became weaker, and at midnight a doctor was called.

At this time, patient was in deep shock and seemed too weak to move. She died at 10:30 the next morning.

Autopsy showed a ruptured ectopic preg-

nancy. It is the consensus of opinion that operation should be attempted regardless of shock, giving supportive treatment and transfusions at the same time. If shock is not too severe, it is better to wait until the bleeding vessel is tied before starting the transfusion; however, in extreme cases, it may be given as soon as possible. Delay is dangerous.

A. W. BINGHAM, M.D.

THE PRESIDENT'S PAGE

NUMBER NINE

COMPULSORY HEALTH INSURANCE

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

The most controversial health issue before America is *compulsory health insurance*. Last July the National Health Conference proposed a health program, the underlying altruism of which met with enthusiastic approval by the medical profession, but it included compulsory health insurance. Doctors ought to know more about health problems than any other group. They believe that, by the elimination of objectionable and extravagant features, notably compulsory health insurance, the National Health Plan may take its place with the great documents of human history.

The House of Delegates of the American Medical Association on September 17, 1938, condemned compulsory health insurance. "It is"—I quote from their unanimous report—"a complicated bureaucratic system which has no place in a democratic state. It would undoubtedly set up a far-reaching tax system, with great increase in the cost of government. That it would lend itself to political control and manipulation, there is no doubt."

On October 31, 1938, seven practicing physicians, representing the profession of America, met with the Government's technical ad-

visory committee in Washington. One of the seven, Dr. Irving Abell, President of the American Medical Association, in his report of this conference indicated that all differences of opinion could probably be adjusted, except the question of *compulsory health insurance*,—and he intimated that its proponents seemed to have the better of the argument.

It is our duty, therefore, to familiarize ourselves with compulsory health insurance. If it is a measure which will benefit the people of America, organized medicine ought to endorse it, regardless of its influence upon our own profession, which always has been, is now, and ever shall be altruistic. The health of the people is our prime consideration, and in the last analysis is the concern of the State. Doctors are instruments of the government, licensed by the State. The practice of medicine is a franchise granted until our acts become anti-social. How far can the State go toward socialized medicine? All the way if it will. The medical profession has no defensive weapon against complete government control, except public opinion. But as long as America is a democracy, public opinion is the supreme law.

QUESTIONS ON COMPULSORY HEALTH INSURANCE

In determining whether or not to adopt compulsory health insurance, America must have several questions answered.

1. What has been the experience of other countries?

2. What is the scope and coverage of compulsory health insurance?

3. What will it cost?

4. How will it be administered?

5. Will it cause friction?

6. What about certification of illness?

7. Is it selective or comprehensive?

8. Does it work well with public health services?

9. Does it produce better health?

10. Is it a step toward totalitarianism?

Let us answer these questions *seriatim*.

1. EXPERIENCE OF OTHER COUNTRIES

Compulsory health insurance now exists in twenty-five countries, including Germany, Italy, Russia, Japan, England, and France. In 1924 Chile, and in 1936 British Columbia, passed the first compulsory health insurance laws enacted in the Western World. Once having adopted it, none has discarded it, and all have expanded its scope.

2. COVERAGE AND SCOPE

The plans vary in coverage and scope, but all have a family likeness. They provide medical care, and cash for wage loss due to illness. Most of them apply to wage earners of low income only, and not all of them are insured. The percentage of wage earners covered varies

from 68 in Germany to 80 in England. The benefits are medical and maternal care, funeral costs, and cash to reimburse from one-half to two-thirds of wage loss caused by sickness. Medical care continues up to twenty-six weeks, after which the insured goes on pension at a lower rate.

The kind of care varies. In England only general practitioners and medicines are furnished. In other countries specialists, hospitals, prescriptions, and appliances are supplied. In France the insured selects his own doctor and druggist and pays them himself; and is reimbursed up to 60 per cent for home and office calls and 30 per cent for surgical care. France found it necessary to establish clinics to check and verify diagnoses.

3. COST

The cost of compulsory health insurance differs in the several countries, and is borne by the insured, the employer, and the government in varying proportions. It amounts to from 5 to 5.5 per cent or more of the wages. The Epstein law proposed in the United States in 1934 and 1935 would collect three per cent of the pay roll of employers, one per cent of wages, and the government would supply some funds. This would cover ordinary sickness only. When unemployment insurance, disability insurance, accident insurance, death insurance, and old-age pensions are added, the total takes as high as 20 per cent of the pay check. The larger number of people covered, the larger the government contribution.

The Danish scheme covers 45 per cent of the total population—the largest coverage of any country. Under it the state contributes more than 50 per cent of the cost.

Compulsory health insurance is extravagant. Patients under it want none of economy. They want every treatment about which they have heard on the radio or about which they have read, no matter how expensive; and the doctor who does not prescribe these medicines and appliances of doubtful value or worse loses dissatisfied patients from his panel. The cost of compulsory health insurance in the United States has been estimated by actuaries of the largest insurance companies from \$4,000,000,000 to \$8,000,000,000 annually.

4. ADMINISTRATION

Methods of administration differ in different countries. However, they too bear a family resemblance. In most countries mutual benefit associations already in existence became insurance carriers under compulsory health insurance. They did not cover all areas, so that

most countries set up territorial fields. In Germany, for example, 70 per cent of the insured are covered by territorial groups; 10 per cent by mutual benefit societies; and 20 per cent by guilds, miners' unions, etc. These overlap, and so the trend is toward territorial administration.

5. FRICTION

Compulsory health insurance causes endless friction, and is generally distasteful to doctors. In countries where some private practice remains, there is less discontent. Under the capitation system of England the doctors retain some private practice and consultation work. The British Medical Association now approves of compulsory health insurance. But were it not for private practice this might not be true.

Under capitation systems the highest incomes go to those who give hurried and careless services. It has been found that the only way to avoid this evil is to place physicians on straight salaries. When that is done, physician is pitted against physician until fees become so low that the profession is exploited and must resort to collective bargaining. The free choice of physician is abolished because it is expensive, and abuses inevitably arise from signing sick blanks. Doctors the world over resent lay control which always and everywhere has dislocated the patient-physician relationship.

As yet, no system of compulsory health insurance has operated without bureaucratic lay interference. In many countries politics muddies the healing waters. For example, in Vienna the type and scope of medical care depends upon political affiliation.

6. CERTIFICATION

Certification of disability in feigned illness is a headache which aspirin will not cure. It brings to the office scores who are not sick, but who merely desire to be considered sick. Many a man selects his doctor, not for his skill, but for his easy conscience in signing sick blanks. If the physician is relieved of certification, special salaried medical officers must fill the blanks, and this necessitates two examinations and adds to cost and confusion.

7. SELECTIVE OR COMPREHENSIVE?

Compulsory health insurance is *selective* and *not comprehensive*. It does not benefit all members of the low-wage group. It cannot be applied to small merchants, farmers, artisans, etc. Regular premium collection from these self-employed individuals is difficult and expensive, and the percentage of normal earnings by them is difficult to determine. No system covers the

young, and the old. All cover the middle-aged healthiest group—the wage-earners. As a matter of fact, those in the extremes of life need protection the most. The only solution is to waive individual collection, and to finance the plan by general tax funds. No country has taken this drastic step, except Russia.

8. DOES IT WORK WELL WITH PUBLIC HEALTH SERVICES?

Coördination of community public health services under compulsory health insurance has been impossible. Government agencies provide a wide array of health services, including public health, hospitals, and the care of the indigent. The British Royal Commission on Health Insurance stated:

"We feel sure that, the wider the scope of these

services, the more difficult will it be to maintain the insurance principle. The ultimate solution will lie, we think, in the process of divorcing the medical profession entirely from the the insurance system, and recognizing it * * * as a service to be supported from the general public funds."

9. DOES IT PRODUCE BETTER HEALTH?

The Secretariat of the League of Nations has declared that the United States is the healthiest nation on earth. Under the present system of medicine the span of life in America has been lengthened more than twenty years, and this country enjoys the lowest death rate in recorded history.

10. IS IT A STEP TOWARD TOTALITARIANISM?

It is not just a step;—it is all but the *final* step.

COMPULSORY HEALTH INSURANCE

PROS AND CONS SUMMARY

PRO

More people will receive the benefit of medical care.

CONTRA

More people will come under the *doctor's eye*, but not under his stethoscope. Superficial diagnosis and careless treatment are inevitable under compulsory health insurance. A look and a bottle are of doubtful benefit.

PRO

Compulsory health insurance gives a sense of security and confidence, and eliminates worry in sickness.

CONTRA

Only wage-earners are covered. No provision is made for the young and the old, the dependents, and the unemployed, and the unemployable,—the very ones who need insurance most. The sense of security and confidence which shines on the faces of the ill at the very sight of the family doctor plays no insignificant part in recovery. All this is lost under robot medicine. To take away the free choice of physician destroys intimate patient-physician relationship, the value of which cannot be computed by statisticians nor measured in dollars and cents.

PRO

Insures and stabilizes incomes of physicians.

CONTRA

In the beginning every country provides attractive remuneration for the doctors; but as costs mount, officials sell to the lowest bidders until physicians' salaries fall below the wages of artisans. The first country to adopt compulsory health insurance is now suffering from a shortage of physicians, and is eliminating two of the necessary years of training. Security of income destroys the competitive urge.

During the past five years 80 per cent of members of The Medical Society of New Jersey have taken post-graduate work voluntarily under our present system. In countries under compulsory health insurance post-graduate work is limited almost entirely to American doctors.

PRO

Under compulsory health insurance, diseases are discovered in their early stages and preventive medicine is improved.

CONTRA

Under a system where as many as eighty patients and individuals who desire to be considered patients crowd into a doctor's office at once, they can expect only a look and a bottle.

The look may reveal acne and strabismus, but early tuberculosis and latent syphilis pass undiscovered. No country has been able to correlate public health services and compulsory health insurance.

PRO

With physicians' incomes assured, they have security and time to advance medical science.

CONTRA

Since Russia enacted compulsory health insurance, only two medical contributions have emerged from that vast communistic country,—state abortion hospitals, and canned cadaver blood for transfusions.

Before compulsory health insurance, Germany and Austria were post-graduate Meccas. The United States without compulsory health insurance is now the post-graduate center of the world.

Under compulsory health insurance, one-third of the doctors' working hours are used in filling endless forms. His fingers are stained with ink instead of iodine.

PRO

In no country where compulsory health insurance has been established has it been withdrawn.

CONTRA

By the same token, in no country where totalitarianism has been established has it been withdrawn. But that does not convince thinking men that Fascism, Communism, or Nazism are beneficent gifts to mankind.

PRO

In every country that has adopted compulsory health insurance, the tendency has been toward expansion rather than toward contraction.

CONTRA

This is true; but so it is with the opium habit. The truth is that compulsory health insurance is an opiate offered by socialists as a panacea for our national economic ills. At first the fumes are pleasant and produce expansive dreams, but they obtund our sense of duty, and benumb our moral fibre. If America uses the juice of this socialistic poppy, we will soon become addicts. Those qualities that made this nation great will forever disappear,—self reliance, self respect,—and the incentive to thrift. The pipe dream of economic security without work will produce a race of spineless suppliants who crawl to the Government for support morning, noon, and night.

ATTITUDE OF NEW JERSEY

Out of accumulating experience medicine is seeking—by scientific methods, rather than by the spending of astronomical sums of money—the same altruistic goal that is set up by the *National Health Conference*. Indeed our goal was set up for us by our own medical forebearers. That goal is—the *adequate medical care of all the people*,—not of wage-earners alone, but of *all* the people, regardless of age, of economic or social status, or of political affiliation. In America both the rich and the poor receive the best medical care of any people on earth. But the distribution of medical care to that large, proud group composed of the *self-supporting middle class* needs to be improved.

Before the National Health Conference ever met, more than 2,000 experiments in *group practice* were being conducted by and with the approval of organized medicine. The first three cent a day hospital insurance plan in America was started in New Jersey. In April, 1938, the New Jersey plan enrolled 33,000. This number had increased to more than 100,000 on January 1, 1939. But the

hospital insurance plans, and they are now many, do not include insurance against the doctor's bill. For many months the Medical Society of New Jersey has been studying this problem and believes that for four cents a day medical services may be assured, giving patients the free choice of physician. Dr. Read, Snedecor, McBride, Lewis, and Sprague, members of this survey committee, recommend that the plan be instituted as an experiment in one or several counties. Drs. Sprague, Todd, German, Lance, and Rucker are now at work applying this experimental approach in New Jersey.

GETTING TOGETHER

Last July, when social workers, government officials and labor in the National Health Conference announced that their goal was *adequate medical care of all the people*, they joined the doctors in their Hippocratic oath. Let us, therefore, not ignore them with haughty contumacy; but rather let us rather grasp their outstretched hands and press forward arm in arm with them toward our common goal.

COMMITTEE OBJECTIVES

VOLUNTARY MEDICAL-COSTS INSURANCE

By HILTON S. READ, M.D., Atlantic City, N. J.

Delivered before the meeting of Second Councilor District, Jersey City, December 15, 1938

The practice of physic—that is the 1938 model of the art and science of medicine as practiced by the one hundred thousand American doorbell-pulling doctors—need bend a knee to no medical era in any country. The wildest and loudest social disturber will admit that fact. Those who are wildest and loudest, as well as the silent and sanest socially-conscious thinking citizens, within or without the profession, are asking for some improvement in the *distribution* of that art and science. Large segments of organized medicine admit the need of that change.

We boast of the improvements in *diagnosis* and *treatment*; yet we have been trying to get along on an *archaic system of distribution*. The attention of The Medical Society of New Jersey has long been focused on this problem. That focus was sharpened last year by President Herrman, who became acutely aware of the urgency through personal experience.

The recent special meeting of the House of Delegates of the American Medical Association gave added impetus to the newer outlook when it agreed with the National Health Conference that the medical care of the medically indigent is the dual responsibility of *government*, and of *organized medicine*; and the A. M. A. respectfully suggested that *voluntary indemnity insurance* is preferable to *tax-supported medicine* for the self-supporting. It is to this latter proposition that we wish to turn our attention for a few moments tonight.

COMMITTEE TO STUDY CASH INDEMNITY INSURANCE

Immediately after the special meeting of the House of Delegates of the A. M. A. on September 16, 1938, President Carrington appointed a special committee of The Medical Society of New Jersey to study *cash indemnity insurance for medical costs*. That committee, consisting of Drs. Sprague, Snedecor, Lewis, McBride, and Read, immediately went to work to find with all reasonable speed the possibilities of such insurance. At the organization meeting we budgeted our activities, and proposed to consult with insurance companies, the Insurance Commissioner of the State, recognized authorities, organized medical

groups which had this experiment in operation, large consumer groups such as organized labor, manufacturers' association, etc. At this preliminary meeting we had the advantage of the wise counsel of Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, and of Dr. Frederic Elliott, former Chairman of the Medical Economics Committee of the Medical Society of the State of New York.

A subsequent meeting was held at which members of the committee reported on their research. From these we learned some of the drawbacks of policies in operation by certain companies, the viewpoint of the large insurance companies, and that of experts and consumer groups. We also had advantage of very lengthy and frank discussions by medical men throughout the country on the possibilities as well as the failures of the various plans which are now under experimentation.

Subsequent to that we conferred with Dr. Michael Davis of the Committee for Research in Medical Economics; and this afternoon we have been in consultation with Professor J. Douglas Brown, Chairman of the Section on Industrial Relations of Princeton University. We have tried to get the viewpoint of all interested parties in the hope that the resultant plan will have a fair chance of success.

This special committee has respectfully summarized its findings to President Carrington, as follows:

1. We believe that some form of voluntary cash indemnity insurance for medical costs is practical, either through old line insurance companies, a non-profit company to be organized along the lines of the hospitalization insurance plan with the endorsement of the State Society, or by the State Society itself.

2. We have recommended the preparation and distribution of a comprehensive brochure to the individual members of the State Medical Society, giving them at some length the results of our studies.

3. We have recommended that, if individual members, by an actual poll, show an interest and willingness to coöperate, the plan be tried out in one, or possibly two counties of this State.

A UNITED FRONT

I bespeak your interest and counsel in this project and your support of the program if, as, and when it is placed in operation. The time to simply rearrange our broad prejudices whenever changes in the pattern of medical care is suggested is, I hope, past. If you agree that some form of voluntary insurance is preferable to tax-supported medicine, I will leave with you three premises that perhaps will condition your thinking when you, at your leisure, study this project. They are:

1. Revolution—not resolution.
2. Civics—not physic.
3. Humanics—not economics.

The time is also past, I hope, when component societies will simply pass resolutions, then gracefully retire, sit on their easy chairs and wait for the officers on the top crust to initiate and prosecute the changes. We must have a united front of all practitioners. We must have the participation of each and every member. If that is revolution, then I am for it; but in New Jersey at least we believe it is but *evolution*.

As pointed out before, the practice of *physic* in the United States is above reproach; and so we do not have to particularly concern ourselves with that. It is difficult to make that art and science available to the consumer at a price he can afford; and so we must concern ourselves, not with *physic*, but with *civics*. We must support those unselfishly-minded men in legislative and executive positions who, like

ourselves, are interested in distributing good medical care to *all* people. We must tear off the white robe of austerity, and don the working clothes of Mr. Citizen. It is civics we need, not more physic.

Each and every person coming into our offices or dispensaries of the large hospitals, coming as they do from infinitely varied sources, is not a heart case or a patient with carcinoma, but rather a sick individual seeking one thing, and one thing only, and that is *relief*. The way in which we handle them and the relief—psychic or physical—which they receive will be the index of our humanist accomplishment. If we do this, we will not have to talk so much about economics; we will not have to wave the Hippocratic oath and pull our hair every time socialized medicine is mentioned, for *economics* is naturally the handmaiden of *humanics*.

I may be a babe in the woods, but I do believe that, if we rededicate ourselves to the ministry of medicine, by substituting revolution for resolution, by increased interest in civics instead of physic, and by the more conscious application of *humanics* instead of *economics*, we shall recapture that shrine in Mr. Everyman's heart which will move him to say with Voltaire:

"There is nothing more enviable in life than a physician who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, exercises his art with caution, and pays equal attention to rich and poor."

OBJECTIVES OF THE COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

By CHRISTOPHER C. BELING, M.D., Newark, N. J.

A. MEDICAL DEFENSE

The work of the committee has been directed towards a further increase in the percentage of members insured so that it may obtain the 100 per cent goal. It has been striving to maintain an efficient organization and to keep down malpractice suits so that the present low rates of insured premiums can be maintained. These objectives cannot be obtained without the coöperation of the county societies. Over 90 per cent of the members have already been insured. There are about 300 doctors who are still uninsured. The work of securing their applications is being gradually done by our official broker, who has been in contact with each member.

During the year plans have been made to have an attorney, well versed in malpractice litigation, address the various county societies regarding the pitfalls of practice, the avoidance of suits, and the rights and privileges of the doctors in the practice of the profession.

The problems of the Medical Defense Committee are difficult and delicate. There is much misunderstanding about the activities of the committee. The committee wishes to urge upon every member of the State Society to obtain his insurance policy through the official agent who has been authorized to act on our behalf by the State Medical Society. In this way the best interest of every doctor, as well as that of the profession at large, will be served.

B. ACCIDENT AND HEALTH INSURANCE

Under the new plan which was adopted at the last Annual Meeting, more than fifty doctors have subscribed to the plan within the last three months, a larger increase than in similar periods in the last ten years that the *Group Accident and Health Insurance* has been in effect in our Society. This increase is proof that many doctors have realized the broad coverage and advantages of this particular policy. With the exception of half a dozen cases, where a representative made a personal call on a physician or those who have obtained insurance, the physicians took insurance on their own volition without any sales pressure.

There is not another accident and health insurance contract in the state today that has as one of its features the setting up of an arbitration committee for the settlement of claim disputes between policy-holders and the company an arbitration committee that is completely within the control of the Insurance Committee of the State.

It is recommended by the committee that a letter informing members regarding Health and Accident Insurance should be sent to every member of the Society from time to time.

The work of our committee will be enhanced by publicity given to the following:

1. Every member of the State Society should take his insurance through the recognized official broker, and not through any other agency.

2. The advantage of the present health and accident contract should be placed before every member of the Society.

Committee:

CHRISTOPHER CHARLES BELING,
Chairman

JOSEPH WALLACE HURFF,
Vice-Chairman

JOHN CHARLES MCCOY

GEORGE THOMAS TRACY

WILLIAM CARTER WESCOTT

WELLS P. EAGLETON, *Consultant*.

OBJECTIVES OF THE MENTAL HYGIENE COMMITTEE

By JAMES S. PLANT, M.D., Chairman, Newark, N. J.

The Mental Hygiene Committee, just as in previous years, has had essentially the problem as to whether it favored an intensive educational campaign reaching the practicing physician of the State; or a continued support of the present clinic development in the State. The State Department of Institutions and Agencies operates, in conjunction with each of its hospitals, a mental hygiene clinic which covers the area that its own particular hospital represents. In addition to this, there are developments as county or municipal affairs in a number of areas of the State.

The Mental Hygiene Committee this year—just as in other years—has felt that the main part of the job of general education must still be the slow clinical demonstration that the above-mentioned clinics are already carrying on in the State. The committee feels that in every other branch of medicine the so-called "clinical method" has been accepted as the only sound teaching method and believes that a

strengthening of the present clinic program represents the best method of spreading mental hygiene in the State.

Consequently our program for this year has been three-fold:

1. Asking the officers of the State Society to take whatever steps are feasible in supporting and strengthening the present program of mental hygiene clinics in the State.

2. Asking that the subject be presented from this point of view at one of the main meetings of the Annual Meeting of the State Society.

3. Favoring the development in the general hospitals of the policy of giving to neuropsychiatrists positions on the staff an importance and influence equal to that of the other specialties in medicine.

The committee—as in earlier years—recognizes that this is a slow and tedious mode of education, but believes that it is the only sound method.

OBJECTIVES OF THE COMMITTEE ON PUBLIC RELATIONS

By JOSEPH H. KLER, M.D., Chairman, New Brunswick, N. J.

When a physician is solicited to join his county medical society, he is likely to ask, "What benefits will membership give me in return for my dues and my attendance at the meetings?"

The dominant objective of the Committee on Public Relations is to inform the people regarding the policies and projects of The Medical Society of New Jersey and its component county societies, particularly along the lines of public health. Physicians are deeply concerned with the health of their patients, and are conscientiously striving to prove themselves to be laborers worthy of their hire. It is therefore proper for a practicing physician to ask, "What definite advantages may I expect from membership in the county medical society?" The answers are contained in the following paragraphs:

1. SELF-PRESERVATION

Physicians can protect their professional rights and privileges only through organization and united effort. Membership in the county medical society confers membership in The Medical Society of New Jersey and in the American Medical Association. There are approximately 140,000 practicing physicians in the United States. One man working alone cannot accomplish much in the protection of his profession however capable he may be. But 140,000 men standing together can exert an influence more than 140,000 times as strong as the individual alone. The strength is multiplied more than that because the 140,000 can get the support of other groups. It is *groups* and *blocs* rather than individuals which mould public opinion. And it is groups and blocs which can exert the most influence in legislative halls. The first great reason for membership in the county medical society therefore may be said to be *self-preservation*—the preservation of the private practice of medicine through united action.

2. PERSONAL REPRESENTATION IN MEDICAL COUNCILS

Organized medicine determines the principles which govern, or are supposed to govern, the conduct of physicians in pursuing their calling. The ethical physician who conforms to these principles but who is outside the ranks of organized medicine is being governed without representation. Because he is not a member he has no voice in the policies of the organ-

ization. Organized medicine exercises a disciplinary influence over the practice of medicine by individuals. This protects the ethical practitioner from the unfair competition of unethical practitioners. The second reason for membership is therefore *personal participation* and representation in the organization which governs physicians professionally.

3. ENFORCING EDUCATIONAL STANDARDS

Organized medicine determines the educational standards for the practice of medicine. This, too, is in the interests of the preservation of the profession because high standards keep out, or at least keep down, the number of the unfit. Educational requirements determine the future status of the medical profession. The physician who remains outside the ranks of organized medicine entrusts to other hands the future status of the profession of which he is a member.

4. SCHOOL OF INSTRUCTION

Organized medicine provides the opportunity for personal *professional improvement*. It is a school for continued professional education. This is accomplished through hearing and discussing scientific papers; through post-graduate and refresher courses; through consultation facilities promoted by county medical societies; and through medical journals published by medical associations. There could be no medical journals, as we now know them, if there were no professional organizations to finance their publication.

5. STANDARDIZATION OF MEDICAL WARES

Organized medicine gives professional assurance in the selection of the products we use. We can rely upon products accepted by the Councils of the American Medical Association and use them with confidence. If there were no American Medical Association, and no association of physicians, the individual physician would be without this benefit. He would be in doubt as to what drugs he could prescribe with safety, and what foods he could recommend with confidence.

6. HOSPITAL STANDARDS

Organized medicine establishes the standards for hospitals. Any physician who sends patients to a hospital will appreciate the fact that his medical society helps to make the hospital an institution in which he will find facilities

for carrying on his work, and efficient and sympathetic care.

7. ELIGIBILITY FOR HOSPITAL APPOINTMENTS

Most hospitals require that staff members be members of the county medical society. Membership on a hospital staff improves the physician scientifically and advances him professionally.

8. SECURING FACILITIES FOR PRACTICE

Organized medicine is able to secure facilities needed by practitioners. Many hospitals owe their existence to the efforts of county medical societies.

9. STUDY OF PROFESSIONAL PROBLEMS

County and state medical societies facilitate the study and solution of medical problems. Specialized work of special committees, financed by medical societies, has contributed greatly to the knowledge of many diseases and has made the work of the general practitioner easier.

10. CORRECTING ABUSES

Organized medicine is able to investigate and expose abuses in the field of health care. Many quacks and charlatans have been exposed by the American Medical Association. This con-

fers two direct benefits upon every ethical practitioner;—it protects him from the competition of the unscrupulous; and it protects the profession of medicine from degenerating to a point where the public would insist that government step in to remedy the abuses.

ECONOMIC BENEFITS

An eleventh—and a very practical—reason for membership in the county medical society, is that membership confers an economic benefit on physicians. The members of the county and state medical societies get reduced rates on professional insurance, and on public liability insurance on their automobiles. This reduction is enough to pay the county medical society dues; and therefore all other advantages of membership become gratis.

12. BROTHERHOOD OF DOCTORS

The county medical society interests members in a common brotherhood of purpose and unity of methods. Its official representatives are the advisers of the community in all health activities in which public officials and health organizations are engaged. The expert advice of experienced medical leaders is doubly necessary in securing the enactment of wise legislation regarding the distribution of medical services.

BOOK REVIEW

TUBERCULOSIS AND LEPROSY, The mycobacterial diseases: Editor, Forest Ray Moulton; Publications Committee, E. R. Long, G. W. McCoy, E. B. McKinley, M. H. Soule, W. C. White. Symposium Series, Vol. I., The Amer. Assn. for the Advancement of Science, 1938.

There are two types of acid-fast mycobacteria. Some strains do not produce disease,—for instance the timothy grass bacillus and the smegma bacillus. Others are of a different virulence and produce disease,—for instance, the mycobacterium leprae, the mycobacterium tuberculosis, and the Johne's bacillus which takes a heavy toll among cattle and allied species. The characteristic feature of the disease-producing mycobacteria is the fact that they thrive inside of a peculiar cell, the monocyte. The function of the monocyte is not well known. Its prevalence in certain organs (lungs, lymph glands, the gut, spleen and liver) seems to indicate that this cell is of a very delicate chemical significance.

A general introduction by White is followed by a symposium series on the morphology, chemistry, immunity, and pathology of tuberculosis (Kahn, Nonidez, Anderson, Menzel, Seibert, Lurie and Sabin) with a final discussion on the common characteristics of the acid-fast bacteria by Corper. Stiles, Feldman, Crawford, Daines, Hagan and Aronson cover the subjects on tuberculosis in domestic animals, the histopathology of the intradermic tuberculin reaction in cattle, the specificity of this

reaction in cattle and laboratory animals, skin lesions in tuberculin-reacting non-tuberculous cattle which are probably caused by certain acid-fast bacteria and, finally, paratuberculosis (Johne's disease) in cattle and sheep. The chapter on leprosy is discussed by Soule, McKinley, Black, Doull, McCoy, Hopkins and Hasseltine and deals with the bacteriology, immunology, pathology and epidermiology of leprosy and discusses leprosy in the United States, the heredity question, and advocates institutional segregation. A summary on mycobacteria is given by Edmond R. Long. The mycobacterial diseases have two things in common: (1) The germs are distinguished from other bacteria by their staining property (acid-fastness) "due in turn apparently to mutual possession of certain chemical substances"; and (2) a characteristic response of the infected animal (proliferation and accumulation of monocytes and the formation of epithelioid cells). Mycobacterial diseases not only occur spontaneously, but can be produced experimentally at will. Our laboratory work explains conclusively the great variability of these diseases. The different clinical pictures depend on the "interplay of bacteria and animal cells, each with its individually characteristic content of biologically active chemical constituents".

This is a very instructive, and well-written symposium. The illustrations are excellent.

FELIX BAUM, M.D.

STATE SOCIETY ACTIVITIES

WELFARE COMMITTEE

A special meeting of the Welfare Committee was held on January 9, 1939, at 2 p. m. in the Stacy-Trent Hotel, Trenton, with Dr. Hilton S. Read, Chairman, presiding. Those present were:

Atlantic County—

Hilton S. Read, Chairman
William J. Carrington, Ex-Officio
David B. Allman

Bergen—

G. Barton Barlow Walter J. Farr
Charles Littwin

Burlington—

S. Emlen Stokes

Camden—

Ernest G. Hummel R. L. Sharp

Cape May—

Harry B. Walker

Cumberland—

Millard F. Sewall

Essex—

Edgar P. Cardwell H. Roy Van Ness
Harry N. Comando Alfred Stahl, Ex-Officio

Gloucester—

Chester I. Ulmer Wendall J. Burkett

Hunterdon—

Barclay S. Fuhrmann

Hudson—

James F. Norton Joseph F. Londrigan
B. S. Pollak

Mercer—

D. Leo Haggerty Charles H. Mitchell

Middlesex—

George W. Fithian Jacob J. Mann
Henry Haywood, Jr. William C. Wilentz
Joseph H. Kler

Monmouth—

C. Byron Blaisdell Barclay W. Moffat

Morris—

Byron G. Sherman George J. Young

Ocean—

Eugene G. Herbener

Passaic—

Wright MacMillan

Salem—

Not represented

Somerset—

Frank L. Field

Sussex—

James H. Spencer, Jr.

Union—

Norman W. Burritt Herschel S. Murphy
Frederic W. Lathrop

Warren—

William H. Varney

Advisory—

Robert P. Fischelis, Phar. D.
Frederic J. Quigley, M.D.

Secretary—

LeRoy A. Wilkes, M.D.

The object of the meeting was the consideration of the question whether or not to reintroduce Assembly Bill 511 for the regulation of the practice of medicine. Secretary Wilkes reported that twenty of the twenty-one county medical societies of New Jersey had voted in favor of reintroducing Assembly Bill 511; but that Essex County, with one-quarter of the membership of the State Society, is opposed to the corporate practice section of the Bill, on the ground that, in the opinion of its legal adviser, it sanctions undesirable forms of corporate practice which have developed in the administration of the Workmen's Compensation Law.

Dr. Pollak, Chairman of the Committee on Legislation, presented the opinion of two legal advisers of The Medical Society of New Jersey, that the bill does not discuss the objectionable features of the system of corporate practice which has grown out of the Workmen's Compensation Act; and neither enlarges the rights of employers, nor diminishes those of physicians.

After considerable discussion, it was unanimously voted that the Welfare Committee approve the re-introduction of Bill A-511, contingent upon a unanimous agreement among the legal advisers, and the approval of the Essex County Medical Society.

The Welfare Committee approved the *pater-ity blood-test bill*.

LEROY A. WILKES, *Secretary*.

TUBERCULOSIS CASE-FINDING IN PUBLIC SCHOOLS

By A. E. JAFFIN, M.D., Jersey City, N. J.

Chairman, Advisory Committee on Tuberculosis, The Medical Society of New Jersey

The following statement of principles and standards regarding "Tuberculosis case-finding among pupils in public schools" was prepared by the Advisory Committee on Tuberculosis, under the Chairmanship of Dr. A. E. Jaffin, in reply to questions propounded by Dr. Allen G. Ireland, State Director of Health and Physical Education; and was formally approved by the Sub-Committee on Public Health, and by the Welfare Committee (Jour., Jan., p. 40). It is now published in *The Journal* for the information of the members of the medical profession of New Jersey. Reprints will be distributed to school physicians.

1. Q.—How valid is the tuberculin test?

Is its validity such that we may assure parents that the positive or the negative reaction is absolutely correct?

What are the exceptions, if any?

Should the school administrator be concerned about exceptions to the extent of interpreting them to parents?

Ans.—The tuberculin test is one of the most reliable tests that we have for determining whether or not tubercle bacilli have at some time entered the body. If positive, it does not necessarily indicate the presence of tuberculosis, the degree of infection, nor the extent of damage done, if any.

For all practical purposes, exceptions to this statement may be ignored. They should not cause worry to parents. (See also answer to Question 9.)

2. Q.—Which grades should be tested?

Is there not justification for testing first grade pupils? the kindergarten?

Why is emphasis given to testing high school pupils? Is the reason wholly economic?

Ans.—In answer to this question it may be said that the ideal plan would be to test children of all grades and ages.

First Grade Pupils—In this group one is likely to find so small a number of infections as to hardly make the effort worth while on a very large scale. On the other hand, experience has shown that very young children with positive tuberculin reactions will serve as leads to a large number of open cases of tuberculosis that were active sources of infection.

Kindergarten—The same may be said of this group.

High School—The high school age is receiving special attention for several reasons. First, because of the high morbidity and mortality rate known to exist between the ages of 15 and 25. Secondly, because in the average high school a large percentage of this im-

portant age group is available under ideally-controlled conditions. More cases of tuberculous infections are likely to be found in this age than in the lower grades.

3. Q.—When is re-testing advisable?

Ans. — All tuberculin-negative students should be re-tested at least once a year. All tuberculin-positive students should be re-x-rayed at least once a year, unless something abnormal is found, when the frequency of re-x-raying will depend upon the particular circumstances in each case.

4. Q.—Is the Mantoux test so definitely superior to other tests that the question of choice may be ignored?

If not, do you care to name a preference and state your reasons?

Ans.—The Mantoux test is definitely superior to other tests because:

1. It is twice as sensitive as the scratch test of Von Pirquet.

2. It is an exact quantitative test.

3. The response when positive is more definite, and more prompt than in all other tests.

However, as a second choice, especially in the face of objection to the "Needle", the Patch test may be used. The following are the objections to the Patch test:

1. It must be kept dry.

2. It must not be interfered with by the child.

3. Frequently when examined at the end of 48 hours, it may be negative, and require four days for a reading.

4. Under the best of circumstances it is at least five per cent less reliable than the Mantoux test.

5. The greater cost of each test would also become a financial problem if planned for a large number.

5. Q.—What is the significance of different degrees of reaction?

Is this something to concern school administrators, or even school physicians?

Should any attempt be made to interpret "degree of reaction" to parents?

Ans.—Different degrees of reaction have no significance beyond the fact that they indicate different degrees of *sensitivity*. This has no bearing upon the question of the *amount* of infection or disease, and need not concern school administrators or even school physicians. It is better not to confuse the minds of parents with any attempts to interpret degrees of reaction.

6. Q.—Should all positive reactions be x-rayed? If the answer is "No", what are the bases for exemption?

Are there indications to warrant x-raying of negative reactors?

Ans.—All positive reactors should, without exception, be x-rayed.

With reference to negative reactors, an x-ray is not necessary to exclude tuberculosis; but it is frequently advisable for certain special reasons, such as malnutrition, suspicion of heart disease, chest deformity, or recent non-tuberculous lung infections such as pneumonia, or the presence of symptoms of chronic bronchitis or pulmonary disease of non-tuberculous character.

7. Q. Do we know enough about the accuracy of the paper film to assure school administrators that it is satisfactory?

What should administrators know about the reliability of paper films, both for their own understanding and for the information of inquiring parents?

What indications justify doubt in the reliability of the paper film in specific individual cases?

Ans.—We know that with the present highly improved technic in the hands of skilled operators, we can secure paper films that will reveal chest abnormalities as clearly as celluloid films. This is particularly true in individuals under 150 pounds.

After an experience of several years with paper films in various parts of the country, it is generally agreed by the users of this method that paper films are quite satisfactory in the "Sifting" process or screening out of abnormalities. A special committee of the American Medical Association has investigated the question very thoroughly, and has approved paper-base films for chest studies with the following reservations:

1. They admit the possibility of missing a small percentage of minimal tuberculous le-

sions in both the opaque paper-base films and the transparent-base films, though the possibility is somewhat larger in paper.

2. They point out a great field of usefulness in group "Sifting", up to a body weight of 150 pounds.

3. The paper films answer well for recording the extent of lesions to be followed by a clear base type.

4. They discourage the use of paper films for heavy individuals, because of their lack of contrast, the need of higher voltage with the resulting scattered rays.

5. Paper is cheaper.

6. The greater speed with which paper films can be taken is particularly valuable in school surveys, because of the opportunity of carrying out x-ray surveys with a minimum loss of time and disturbance of curriculum to the school, as well as at a lower cost.

8. Q.—Is the *celluloid* film infallible?

Ans.—No. There are lesions in the lung so small and so translucent to the ray that they may not be demonstrable in *any* films.

9. Q.—Assuming a positive reaction to the Mantoux, and a negative reading of a paper film, what should be told parents? What explanation for the circumstance? What advice regarding further steps?

Ans.—A positive Mantoux reaction, by itself, does not indicate that a person has tuberculosis. "If the tuberculin test is positive (red and swollen), it means only that tuberculosis germs have at some time entered the body. It does not tell how many there are, or if any damage has been done. It should not cause worry to parents.

"If the test is positive, the child's chest should be x-rayed to be certain that no harm is being done in the lungs. An x-ray examination should also be made of every member of the household to learn if the child is being exposed to an open case of tuberculosis. Frequently this may reveal other cases of tuberculosis before the victim is at all aware of the disease. If no one in the family has the disease, search should be made among the child's playmates or others with whom he comes in close contact. It is perfectly safe for a child with a positive reaction to mingle with other children,—for unless there are tubercle bacilli in his sputum, he cannot pass them to others. Tuberculosis often exists in a concealed form in unsuspecting persons, and it is important to make the discovery in order to prevent further spread of the disease."

The parents should also be advised that the

tuberculin-positive student should be x-rayed regularly at least once a year so as to detect any evidence of reinfection as early as possible. If the tuberculin test is negative, no x-rays are necessary until a subsequent tuberculin test proves to be positive.

10. Q.—Will you outline briefly the follow-up procedure for the average school district? That is, given results of the test and the x-ray, what are the next steps in the school program?

Ans.—After a tuberculosis survey, the parents are advised in a general way as to the results, and instructed to see their family physician for further explanation of the same.

Parents receiving reports to the effect that the Mantoux test was negative are advised of the importance of having the children retested annually by their own doctor, as long as they are negative.

In the case of the child who had a *positive* Mantoux with a *negative* x-ray, the parents are advised to have the child x-rayed, at least once a year thereafter through their own physician. They are also advised to have all other members of the household x-rayed, and all children under fifteen Mantoux-tested.

In the case of those children in whom the x-ray showed some abnormality, the parents are particularly urged to take the report of the findings to their family physician at once. He is to be further informed of the desirability of communicating personally with those conducting the survey, who should endeavor to co-operate with him to the fullest extent on behalf of his patient. For those who cannot afford private service, the facilities of the Tuberculosis Clinics should be made available.

With reference to the schools, plans are for-

mulated for continuing these surveys so as to test all new admissions each Spring, as well as those previously tuberculin-negative.

11. Q.—Both the school and the regulations of the Department of Health require that pupils having a communicable disease be excluded from school. This needs interpretation in terms of tuberculosis, because, as I understand it, a positive Mantoux may result from a healed lesion. Should we exclude all positive reactors pending final diagnosis? Should we do nothing until a diagnosis of active disease is made? Are there types of active cases that are non-communicable, and may therefore remain in school? Should all active cases be excluded?

Ans.—There should be no exclusion until the x-ray reveals findings that would warrant it. No action can be recommended until the x-ray findings call for it.

There are no types of active cases that should remain in school, regardless of whether they are communicable or not, because all active cases require treatment. All active cases would therefore necessarily have to be excluded.

Committee,

ABRAHAM E. JAFFIN,

Chairman

SAMUEL B. ENGLISH

NORMAN W. BURRITT

LEO B. DRAKE

CLYDE M. FISH

MARCUS W. NEWCOMB

HAROLD S. HATCH

JOHN E. RUNNELLS

HARRY B. WALKER

FREDERIC J. QUIGLEY,

Consultant.

PUBLIC HEALTH COMMITTEE

1. DECEMBER MEETING

A meeting of the Public Health Committee was held December 7th, 1938, 3:00 p. m., in the Academy of Medicine, Newark. Those present were Dr. Nichols, who presided; Dr. Lathrop, Dr. Blaisdell, Dr. Fort, Dr. Ireland, Dr. Knight, Dr. Levy, Dr. Moffat, Dr. Murphy, Dr. E. Zeh Hawkes, Dr. Frankel, Dr. Stuart Hawkes, Dr. Rissoli, Dr. Cronk, Dr. Stone, Dr. Robbins, Dr. Norman M. Scott and Dr. Wilkes.

MATERNAL WELFARE

Dr. Levy reported in Dr. Bingham's absence that wider distribution of pre-natal clinics seemed to be the most urgent need in the minds

of the Maternal Welfare Committee. Dr. Levy felt that in each County Society a committee to consist of the Field Physician, the Chairman of the Maternal Welfare Committee of the county, two physicians who are members of the County Medical Society, the district supervising nurse of the Health Department, and the local district health officer might work out a plan for pre-natal care. Dr. Levy stated that the Maternal Welfare Committee thought it might be possible to work out a practical plan of assigning these pre-natal cases to individual physicians who would take care of the indigent cases. The doctors to whom such cases would be sent would have to be qualified as are em-

ployees of the Health Department, and be willing to accept the responsibility of caring for these cases and reporting on them when required, and would have to do everything in their power to see that the plan so worked out was successful and practical. If the County Societies want to accept this responsibility the State Maternal Welfare Committee will attempt to develop such a plan for discussion.

DIPHTHERIA IMMUNIZATIONS

A general discussion of the value of one and two doses of toxoid resulted in the general approval of two doses of toxoid for the private practitioner, and in the health department where the parents would return for the second dose; but a feeling was expressed that the single dose would more adequately protect the community if used on a wide enough spread of the population in the susceptible age group. The literature quoted indicated that 70 per cent could be immunized by two doses whereas the single dose gave only 60 per cent even with a precipitated toxoid.

CRIPPLED CHILDREN

Dr. Moffat stated that the Crippled Children's Commission will admit mentally deficient cases with crippling defects only where an operation to increase ability to move or walk or to improve the general health is the immediate objective.

Dr. Beling has been appointed as an adviser to the Committee on Neurological Problems of the Babbitt Hospital, which houses the experiment on birth injury cases. The year's observation on these is encouraging as a scientific experiment with some improvement shown by the cases, but at a rather high cost.

OCCUPATIONAL DISEASES AND INJURIES

Dr. Fort reported that the committee at the present time is fact-finding and is working with the dermatologists to broaden the Workmen's Compensation Law, especially for workers in oil who are frequently attacked by furunculosis and other compensable forms of dermatoses. The committee will provide the Public Health Committee with the expanded list of added compensable diseases as soon as it has been completed.

The report of the *Tuberculosis Committee*, by Dr. Jaffin, on "Tuberculosis Case-finding in Public Schools" was accepted. It is printed on page 109 of this Journal, and reprints will be distributed to school physicians.

VENEREAL DISEASE COMMITTEE

Dr. Blaisdell reported that his committee had approved the efforts of the Health Department

to obtain Wassermann tests in groups of industrial workers in the factories. In connection with the Premarital Law requirements, a fee of \$3.00 for taking the Wassermann test and for the subsequent examination and pronouncement of freedom from communicable diseases as required by law, was recommended. The cost of making the test is, of course, not included and the State Department of Health makes these tests free.

The Department of Health Venereal Disease Control Bureau is investigating the conduct of venereal disease clinics in hospitals, and the follow-up of patients who do not come back voluntarily.

The Morris County Medical Society proposes a plan whereby certain physicians are designated by the Health Department and paid fifty cents per case, rather than \$5.00 per hour, clinic charge. The Venereal Disease Committee voted against this plan in principle and also the \$100 retainer for physicians proposed; but stated that if the State Public Health Committee approved of it as an experiment, it could be referred to the Medical Practice Committee for an opinion.

SCHOOL HEALTH PROBLEMS

Dr. Ireland stated that the Commissioner of Education was going to hold a conference regarding legislation as it affects school problems. This was brought about by the application of osteopaths for appointment as school physicians.

Dr. Ireland asked the Public Health Committee to consider such problems as stair-climbing in connection with the design of future school buildings which tend to go up in the air as the ground space becomes more limited. The small amount of time available for going from one class room to another results in a speed-up; and Dr. Ireland would like to know the experience of the men as to what effect this had on the child and his heart where stair-climbing is involved.

Dr. Ireland is also working on a problem of studying more intensively illnesses and injuries of athletes, and the effect of previous injuries on the athlete. The factor of emotional strain in competitive athletics is presented for further study.

PAY FOR SERVICES TO CRIPPLED CHILDREN

Dr. Moffat spoke of the studies on remuneration costs if the government were to see orthopedic surgeons paid for work done in behalf of crippled children.

LEROY A. WILKES, *Secretary*.

2. JANUARY MEETING

A meeting of Public Health Committee was held January 4th, 1939, 3:00 p.m., in the Academy of Medicine, Newark. Those present were Dr. Nichols, who presided; Dr. Ireland, Dr. Jaffin, Dr. Knight, Dr. Levy, Dr. Sherman, Dr. Bingham, Dr. Bien, Dr. A. L. Stone, Dr. E. Z. Hawkes, Dr. Carrington, Dr. N. M. Scott, Dr. Wilkes, Mr. Benson, representing Dr. Kler of the Public Relations Committee, and Mr. MacDonald, representing Dr. Mahafey of the State Department of Health.

MATERNAL WELFARE

Dr. Bingham brought up the question of pre-natal care in the rural districts. He reported that some of the rural districts have no clinics for pre-natal care, and that most of the care must be given in the doctor's office. This question was discussed by Drs. Bingham, A. L. Stone (of Camden County), and Levy. Dr. Bingham presented a plan whereby the Field Physician of each county would coöperate with two physicians of the County Society in an organization to care for women needing pre-natal care. Also assisting in this plan would be possibly the Red Cross, Visiting Nurses Association, and the Health Department. The Field Physician would be the chairman of the plan, to sit with the two members of the County Society. A questionnaire would be sent out to members of the County Society to obtain a list of physicians willing to offer their services, sometimes without remuneration, in this plan.

DIPHTHERIA IMMUNIZATION

The Child Health Committee recommended to the State Society that a concise circular giving up-to-date information on the relative merits of toxoid therapy be prepared by the State Department of Health and sent to the doctors in the State.

It was also recommended that the Academy of Pediatrics' "Immunization Procedure" be

printed and distributed to the doctors in the State by the State Department of Health. Before this is done, a copy of the "Immunization Procedure" is to be sent to Dr. Levy. A motion was made and passed approving of this.

NATIONAL YOUTH ADMINISTRATION

Dr. Robbins, Chairman of the Public Health Committee of the Essex County Medical Society, asked about the National Youth Administration, stating that examinations were being given children between the ages of 18-25 working for the N. Y. A. Since there are no more funds for the N. Y. A. at present, the City of Newark is now assuming this work.

The committee recommends that funds be provided by the N. Y. A. for these health examinations. Motion was made and carried that the physicians doing this work should be compensated for their services. It was decided that the economic questions be referred to the Medical Practice Committee and be presented for adoption to the Welfare Committee at its next meeting.

PNEUMONIA CONTROL

Mr. MacDonald informed the committee that a resolution had recently been passed by the State Legislature giving the State Department of Health an additional sum of \$10,000.00 for pneumonia serum. Dr. E. Zeh Hawkes suggested that the State Society thank the Legislature for the \$10,000.00 appropriation, but go on record as saying that an additional \$25,000.00 is needed until the next budget. Motion to this effect was made and passed. This additional money will be needed in view of the present demands, and the fact that the pneumonia season has just begun. This matter is to be taken up with the New Jersey Hospital Association, asking them to join our general pneumonia committee.

LEROY A. WILKES, *Secretary*.

CANCER CONTROL COMMITTEE

A meeting of the *State Cancer Control Committee* with the *Chairmen of the County Committees* was held on Sunday, December 18, 1938, at 2:00 p.m. in the Executive Offices, Trenton, in order to discuss the plans of the county societies. Dr. William G. Herrman, Chairman of the State Committee, presided. There were twenty-eight representatives present, as follows:

Atlantic County—Harold S. Davidson, William O. Roop
Bergen—F. E. Keir
Burlington—H. P. Shipps
Camden—Thomas K. Lewis
Cape May—George F. Dandois
Essex—E. Zeh Hawkes
Hudson—Reeve L. Ballinger
Hunterdon—Barclay S. Fuhrmann

Mercer—J. M. Schildkraut

Elmer Elias

C. Chester Chianese

J. A. Wikoff

D. Leo Haggerty

Middlesex—Edward F. Klein, Joseph H. Kler

Monmouth—William G. Herrman, Otto R. Holters

Morris—Marshall D. Hogan, C. B. Woodman

Salem—C. P. Lummis

Somerset—Augustus S. Knight, E. G. Brittain

Union—W. B. Morris, A. R. Casilli

William J. Carrington, President

Norman M. Scott, Executive Assistant

Mr. William H. MacDonald, State Department of Health.

COUNTY CANCER SURVEYS

Chairman Herrman referred to the committee appointed by Governor Moore in order to ascertain the health needs of New Jersey. The Cancer Committee of the State Medical Society is the natural adviser of the Governor's committee in all phases of the cancer problem.

The Chairman requested each County Chairman to submit by February 1st the following information in a report on his county society and its facilities for the control of cancer:

1. Individual county program.
2. Needs of county.
3. What is being done by the county.

STANDARDS OF TREATMENT

Dr. Herrman reported that for the proper treatment of a cancer case, the following services are needed:

1. Diagnosis, under which may be grouped:
 - a. Clinical findings.
 - b. X-ray.
 - c. Pathological.
2. Planned care; not haphazard trial and error.
3. To give such planned care, there must be available:
 - a. Competent surgeons.
 - b. Competent radio-therapists in both x-ray and radium.
 - c. Competent trained pathologists.
 - d. Other trained personnel, including nurses and follow-up social service workers.

COUNTY SOCIETY PROGRAM

The following program of The Medical Society for cancer control will apply to most counties:

1. Education of physicians in general practice by addresses before the county medical society, and the formation of tumor study groups in the hospitals. We must encourage the general practitioner to become *cancer-minded*, so that he will not fail to recognize at

least the obvious case, and the pre-cancerous cases.

2. Through local advocacy we can make an effort to provide or augment local facilities.

3. We can coöperate with any State-wide plan of service that is ethical and properly planned.

4. We can help organize local aid groups to help educate the public, but, in your Chairman's estimation, general education should become generalized only when we are sure that the profession is awakening, and facilities are present either locally or have been arranged for in coöperation with institutions not too far distant.

ALTERNATIVES

It seems to your chairman that we will soon have to face in this State either:

1. State government control of a State cancer hospital, possibly with State branches, or
2. A private organization planned to give the same service, but not under political control.

The second method of control is to be much preferred.

THE CURIE INSTITUTE

Briefly, a central hospital of the Curie Institute is to be established for the following purposes:

1. The handling of difficult cases from any part of the State.
2. The development of highly trained New Jersey physicians.
3. Research.
4. To own and supervise a radium and radon pool.

Your State committee already endorses the principles of the Curie Institute, and advises local physicians to join the organization of local Curie aides which are now being organized in various parts of the State in order to arouse interest and obtain funds for the Curie Institute.

The Curie Institute officers assure us that they will not compete or interfere with already established competent tumor groups or clinics.

CANCER PROGRAM FOR A SMALL COUNTY

A tentative program for the small county committees at the present time might be outlined as follows:

1. Educate physicians through cancer programs at committee meetings.
2. Organize group studies in local hospitals.
3. Solicit the opportunity to make talks before lay clubs and small groups.
4. Arrange affiliations with nearby already established public or private facilities, so that

patients in the small counties will know where to get proper treatment.

5. Get Boards of Freeholders to subsidize independent cancer cases.

6. Arrange through local Boards of Freeholders for the care of the hopeless cases for whom no longer is medical help of any avail.

CANCER PROGRAM FOR THE LARGER COUNTIES

The larger or urban counties can:

1. Continue to emphasize (a) cancer before the general practitioner, especially pointing out the value of recognizing precancerous lesions; (b) the importance of group diagnosis; and (c) the importance of planned treatment.

2. Support already established facilities.

3. Educate the public by (a) group meetings, (b) lay articles in local newspapers.

4. Gather local statistics or mortality rates and five-year cures.

In urban centers where facilities are complete, all of the above also applies; in addition, Cancer Week exhibits might be arranged and symposia, like Passaic County's program of last year. But if such symposia were arranged, your Chairman would suggest that emphasis be laid upon the treatment of lesions that are especially amenable to treatment, such as the breast, the uterus, the skin, and so forth.

In such locations where facilities are inadequate, the literature for the layman, furnished

by the American Society for the Control of Cancer, may be used with considerable benefit; but it would seem wise to limit its use to localities where complete facilities are available.

DISCUSSION

Dr. J. H. Kler described the educational program of the American Society for the Control of Cancer, and suggested that it be put into operation in New Jersey at once, and not to wait until the proposed Curie Institute can be developed.

Mr. MacDonald, Chief, Bureau of Local Health Administration, State Department of Health, said that the Department has had the cancer problem under consideration and had not yet undertaken the examination of suspected tissues.

Dr. Shipps, of Burlington, brought up the subject of the relation of the family doctor to the patient when patient is sent to clinic. He stated the relationship should be maintained and the family doctor should be invited to sit in at all consultations and treatments of the patient at the clinic, and the family doctor should have charge of the follow-up of the case after the discharge of the patient from the clinic.

Dr. Casilli, of Union, described very fully the Tumor Clinic in the Elizabeth General Hospital.

CONFERENCE ON MATERNAL WELFARE

The regular yearly conference of Committee on Maternal Welfare of The Medical Society of New Jersey was held on January 19, 1939, at the Academy of Medicine of Northern New Jersey, 91 Lincoln Park, Newark, with the members of the State and county society Maternal Welfare Committees and the county Field Physicians attending. The conference was opened at 3:15 p. m. with Dr. A. W. Bingham, Chairman of the State Society Maternal Welfare Committee, presiding over an assemblage of about two hundred physicians and invited guests.

FILM-SHOWING

The film "The Birth of a Baby", which is sponsored by the American Committee on Maternal Welfare, Inc., was shown. The picture is intended for the general public, and is designed to give a clear picture of the creation of human life from conception through actual birth. The film does this simply and clearly. The duties of the mother to herself and her baby are

shown, as are her relations with her physician. The patient-doctor relationship, showing the need for adequate pre-natal care in making the birth of a baby easy through good care, is the keynote of the film.

The film was shown before the conference in order to provoke discussion from physicians most directly concerned with maternal welfare in New Jersey, as to whether or not they should endorse the showing of this film in the theatres of the State under restrictions set up by the American Committee on Maternal Mortality, Inc.

The conference went on record as endorsing the film and its showing.

GENERAL MEETING

The showing of the film and discussion relative to it was followed by a general meeting of the committees present. All counties except Cumberland and Warren were represented.

A discussion of the maternal deaths of 1938 revealed that many of the deaths were entirely

unavoidable, but yet as the lessons from death certificates which were being printed monthly in The Journal show, many of them could have been avoided. With the increased coöperation of county Maternal Welfare Committees and the Field Physicians, the prognosis for cutting down the number of deaths in 1939 seems very good.

PRENATAL CARE

Dr. Bingham said that death certificates were still being received which showed that the deceased had had no prenatal care whatever, probably because of an insufficient number of pre-natal centers. He outlined two systems for dispensing pre-natal care to the indigent and low-wage groups which in many cases should eliminate such occurrences. The recommended systems are as follows:

1. THE MATERNITY CENTER SYSTEM OF PRE-NATAL CARE
 - a. Executive Committee to supervise work, composed of representatives of agencies involved.
 - b. Prenatal Centers, usually in hospitals with a physician in charge.
 - c. Field Nurses—Public Health Nurses, Visiting Nurses, Red Cross Nurses.

The field nurse contacts new patients in the indigent or low-wage groups and gets them to attend a prenatal center at regular intervals. There the patient is given routine prenatal care. The nurse calls on the patient between her visits to the center and helps her to carry out instructions received. In some districts she assists the physician by taking the blood pressure and making a urinalysis. If abnormal conditions are found they are reported to the center, and the patient is sent there for a check-up. If the patient is delivered in a hospital, the nurse may call again when patient goes home.

2. THE COMMUNITY SYSTEM OF PRENATAL CARE.
 - a. Executive Committee to supervise work:—Field Physician, Chariman; two physicians appointed by the President of the County Medical Society; Supervisor of Field Nurses.
 - b. Physicians—those who have expressed a willingness to do this work through a questionnaire sent out by the County Medical Society to every member.
 - c. Field Nurses—The field nurse contacts the patient in the indigent or low-wage group who needs prenatal care. She then notifies the Field Physician, who assigns the patient to a physician in the neighborhood who has agreed to give prenatal care.

PROGRAM AND OBJECTIVES

The program and objectives of the Maternal Welfare Committee for 1939 were discussed,

especially with regard to improved and increased hospital facilities. The county Maternal Welfare Committees, in coöperation with the Field Physicians, were urged to campaign for public support in building up the departments of the hospitals where they do not now exist.

CONSULTANTS

Records for 1938 showed that New Jersey physicians availed themselves of the opportunity to call consultants of their own choice in difficult cases.

From a study of these cases and of the advice given, it seems that all of the consultants gave helpful assistance to the physicians calling them. The importance of choosing a physician experienced in obstetrics was stressed.

RECORD FORMS

It was suggested that, inasmuch as many of the smaller hospitals in New Jersey did not have any method of keeping maternity records except by *cases* from which it was difficult to obtain working figures, it would be very helpful if the Committee on Maternal Welfare endorsed the use of a *summary chart* for keeping uniform maternity case records. A chart of this form was exhibited by Dr. T. K. Graham, Field Physician from Passaic County, as being in use in the Passaic General Hospital. The chart was passed among the doctors, who were highly pleased with the form, and it was decided that the State Society Committee on Maternal Welfare print and distribute copies of the form to the hospitals in New Jersey for use during 1938.

NEO-NATAL MORTALITY

Dr. Julius Levy, Chief of the Bureau of Child Hygiene, showed lantern slides on the subject of "Neo-natal Mortality", and explained them with an interesting running comment.

This was followed by a brief meeting of the Field Physicians.

At seven o'clock an informal dinner was held at the Essex House in Newark.

The conference was resumed at the Academy of Medicine at nine o'clock with an address by Dr. Harrison Martland, Medical Examiner for Essex County and Professor of Forensic Medicine at New York University, on the subject "The Medical Examiner Looks at Obstetrics and Gynecology".

THE ANNUAL REPORTS OF OFFICERS AND COMMITTEES

FOREWORD, BY PRESIDENT CARRINGTON

The time of organizing each new year of administration of The Medical Society of New Jersey was formerly the early Fall, but it has been advanced year by year, until in 1938, the new committees were announced at the close of the Annual Meeting on May 19.

New committees met seventeen days later—on June 5—to hear the announcement of the plans of the newly appointed chairmen, and adopt definite plans of action. The sub-committees and the advisory committees met in the morning with an attendance of 114 members. On the afternoon of the same day the Welfare Committee met, with an attendance

of 82 per cent of its personnel; 72 per cent of the Trustees; and twenty-one interested visitors. This attendance was a prophecy of the activity which has continued throughout the administrative year.

The next administrative year will be started with equally bright prospects if each officer and chairman will be prompt in reporting the accomplishments of the closing year, and making suggestions for the new administration, based on his rich experience during the year which is soon to cease.

The following announcements from the executive and the editorial offices are approved:

SCHEDULE OF ANNUAL REPORTS

In accordance with the custom established in 1934 and followed each year with the approval of the House of Delegates, the *annual reports* of the officers of the Society and the chairmen of committees have been printed in The Journal of the month preceding the annual meeting.

The personnel of the Reference Committees of the Annual Meeting has also been announced in the same issue of The Journal.

This plan will be followed this year.

SCHEDULE OF REPORTS

Since the annual meeting will open on Tuesday, June sixth, 1939, the reports of the officers and the chairmen of committees will appear in the May issue of The Journal, whose normal date of mailing is May tenth. The following schedule of dates for submitting the reports allows a reasonable time for the preparation, approval, editing, and printing of each one.

SATURDAY, APRIL 1, 1939

A draft of the report of each officer and chairman to be completed and mailed to the Executive Offices, so that it may be set in type at once.

WEDNESDAY, APRIL 12

A copy of each report—in type and proof-read—to be returned to each officer or chairman making the report.

SUNDAY, APRIL 16

Each chairman to present his proposed report to his committee for discussion, revision, and approval. The Executive Offices will supply a copy to be given to each member at the

meeting. A schedule of the meeting dates of each committee is printed in each issue of the Journal on advertising pages IV-VII.

Immediately after the close of the meeting, each chairman will return the report in its final form to the Executive Offices, so that it can be corrected and proof-read in its final form at once.

This schedule offers an efficient and economical method of securing satisfaction and promptness in the reports.

SUPPLEMENTARY REPORTS

The only supplementary reports that will be given at the annual meeting will be those of unforeseen events which occur between the date of going to press, and June sixth, when the annual meeting will open. Exceptions will, of course, be made with the reports of the Treasurer and the Legislative Committee, which cannot be presented in their final form until the end of the year.

REPORTS OF PRESIDENTS OF COUNTY SOCIETIES

An innovation, which was proposed by the Publication Committee in its 1938 report, is that each president of a county society shall make a report of the year's activity of his society. This proposition was approved by the Reference Committee, and by the House of Delegates. (See Transactions 1938, pages 12, 51, and 53.)

The President of each County Society will be reminded of this action, and will be asked to submit his report to the Executive Offices *on or before April first*, in order that it may be published in the May Journal.

HENRY C. BARKHORN, *Chairman*
The Publication Committee.

PROPOSED AMENDMENTS TO THE CONSTITUTION

Two amendments to the Constitution of The Medical Society of New Jersey were approved by the Committee on the Revision of the Constitution and By-Laws, Dr. Samuel Alexander, Chairman, at the annual meeting of 1938, and were submitted in writing to the House of Delegates on May 17 and 18, 1938. Final adoption of these amendments will be considered by the House of Delegates, which will open its session June 6, 1939.

The first proposed change is in Article V, entitled "House of Delegates", by the insertion of the words:

"And shall hear appeals from the decisions of the Judicial Council."

(See Transactions 1938, Section 18 B, page 22.)

The amended Article V will read (new clause is in italics):

"The House of Delegates shall be the legislative body, *and shall hear appeals from the decisions of the Judicial Council*, and shall consist of the Fellows, Officers, and Delegates."

The second proposed change amends Article VII, entitled "Councilors", by changing the

word "Delegates" to "Membership". (See Transactions 1938, Section 22 D, page 28; and Section 35 D, page 36.)

The amended article will read:

"The House of Delegates shall organize five (5) councillor districts within the State. This Society shall elect one (1) councillor from among the *membership* (changed from delegates) of each such district; and these elected councilors collectively shall constitute the Judicial Council."

These two proposed amendments are printed in this Journal in compliance with Article XII, entitled "Amendments", which reads:

"This Constitution may be amended by a two-thirds vote of the members present at any annual meeting, provided the proposed amendments have been considered by the Committee on Revision of Constitution and By-Laws, and that they shall have been submitted in writing at a previous annual meeting, shall have been published in The Journal of this Society, and officially sent to each component society at least three (3) months before the annual meeting at which final action is to be taken."

ALFRED STAHL, *Secretary*,

The Medical Society of New Jersey.

Kicks and Konstructive Criticisms will be welcomed in the 1,F form of your survey.

THE OFFICIAL LIST OF MEMBERS

On January 1, 1939, dues were due and payable in advance for membership in The Medical Society of New Jersey during the year.

The official list of the membership in the component county societies of The Medical Society of New Jersey will close on *March 15th, 1939*.

Members whose dues are not paid by that time are dropped from the State Society membership rolls, and their names will not appear on the official list of members. Membership and fellowship in the A. M. A. automatically lapse, for a physician is entitled to a membership or fellowship in the A. M. A. only when

he is a member in good standing of his State Society.

Also, delegates from a county society to the State Society are apportioned according to the paid-up membership from the county on the State Society roster on *March 15th*. No additional appointments of delegates are permitted after that date.

Pay your annual dues promptly for your own sake, and for the benefit of the medical organization whose assistance and inspiration you share.

ALFRED STAHL, *Secretary*,
The Medical Society of New Jersey.

**To "Know Thyself" is the purpose of the State Survey of Medical Services.
Send your estimate of your "Resources and Liabilities", for the State-wide survey of Medical Practice.**

LEGISLATIVE BULLETIN NUMBER ONE

The 163rd Session of the Legislature of New Jersey opened officially on Tuesday, January 10, 1939. No bills were introduced until January 16th.

The following bills of interest to our members have been introduced to date:

SENATE BILLS

S-61—Taggart—January 23—To appropriate \$25,000 for the purchase of pneumonia serum. Referred to Appropriations Committee (Loizeaux, Van Winkle, Zink, Stanger, Dolan). Sponsored by New Jersey Health Department, and The Medical Society of New Jersey.

S-51—Foran (for Hendrickson)—January 23—To Permits household remedies, vermin exterminators, and disinfectants to be sold by stores other than pharmacies. Referred to Miscellaneous Business Committee.

S-51—Foran (for Hendrickson)—January 23—To exempt persons employed in charitable hospitals and institutions not operated for profit from the provisions of the act regulating minimum wage standards. To Labor, Industries and Social Welfare Committee.

ASSEMBLY BILLS

A-62—Wegrocki—January 23—To fix the qualifications of persons eligible to take examinations for license to practice medicine and surgery. To Public Health Committee.

A-25—Forester—January 23—Workmen's Compensation—To provide that a claimant for compensation for compensable occupational diseases shall file his petition within two years from the time such claimant ceased to be exposed to such occupational disease. To Insurance Committee.

A-30—Forester—January 23—Companion bill to A-25. To provide that claimants for compensation for compensable occupational diseases shall file their petitions within two years after the date which such employee was exposed to such compensable disease. To Insurance Committee.

A-31—Forester—January 23—To provide that all diseases resulting from, or caused by, the circumstances or conditions surrounding employment shall be compensable occupational diseases; specifically adds pneumoconiosis as such. To Insurance Committee.

A-35—Friedland—January 23—To double the penalty in Workmen's Compensation cases where accidents happened after employers are notified by the Department of Labor of the existence of the hazard. To Corporations Committee.

A-63—Ward—January 23—To make pneumoconiosis a compensable disease under the Workmen's Compensation Act. To Insurance Committee.

A-48—Mahr—January 23—To provide for an annual eye and ear test for public school children. To Public Health Committee.

A-61—Wegrocki—January 23—To provide for blood tests in court proceedings involving illegitimacy. To Revision and Amendment of Laws Committee.

A-128—Hanna—January 23—To regulate advertising in connection with the sale of eye-glasses, lenses or eye-glass frames. To Public Health Committee.

A-129—Hanna—January 23—To restrict optometrists from hiring out their services to anyone but a licensed optometrist. To Public Health Committee.

LEGISLATIVE BATTLES ARE WON OR LOST BACK HOME

Keep your Senator and Assemblyman informed as to the attitude of The Medical Profession in New Jersey

MEMORIALS

DR. ALEXANDER S. ROSS

Dr. Alexander S. Ross died at his home in Hadonfield, N. J., on January 11th, 1939, at the age of sixty-two from pneumonia. He was the son of an Irish importer and attended the Philadelphia public schools, graduating from Central High School in 1896. He received his degree as Doctor of Medicine from the University of Pennsylvania in 1900. He served a two years' residency at the Cooper Hospital, Camden, and continued his associations with this hospital until his death.

During his early medical life he acted as instructor in anatomy at the Jefferson Medical School. For the last twenty years he had been advisory surgeon to the State Rehabilitation Clinic. He was also industrial surgeon to many of the Camden plants. He was an authority on traumatic surgery in this section. He was a surgeon to many of the

leather manufacturing plants and was a nationally known expert on the diagnosis and treatment of anthrax. He assisted Da Costa in writing the chapter on anthrax in his book on Modern Surgery. He was a surgeon to the Cooper Hospital and consulting surgeon to the Zurbrugg, where he devoted much of his time to the treatment of the ward patients.

In his later years Dr. Ross took numerous trips, which he was accustomed to describe in the consulting room of the Cooper Hospital to the delight of his confreres. He was a wonderful surgeon, and combined with this had a sense of humor and a deep understanding of human nature that made him popular with both his patients and his colleagues.

HAROLD D. BARNSHAW, M.D.

DR. HARRY S. WILLARD

At a meeting of the Medical Board held at the Paterson General Hospital on Tuesday, December 27, 1938, the following resolution was adopted:

Dr. Harry S. Willard joined the Medical Staff of the Paterson General Hospital in 1924 and continued to serve as an attending ophthalmic surgeon until he was called to higher service in another world on December 11, 1938. The years of his connection with the hospital were marked with intelligent effort on behalf of the scientific work of the institution and active loyalty to its general interests and welfare. In his work for his patients, he

joined a human sympathy to professional ability and surgical skill. To staff committees and administrative questions he gave both careful study of problems, and a ready sharing of his time, energy, and interest. He never hesitated to serve the hospital in its relations with the outside world when opportunity offered. And to his colleagues and associates he displayed qualities of character and personality that linger in the memories of his associates.

DONALD B. LOW, M.D., *Secretary.*

DR. ALEXANDER MACALISTER

Dr. Alexander MacAlister was born in May, 1862, and died on November 22nd, 1938, at the age of 76. He was educated at the Philadelphia College of Pharmacy, graduating in 1882, and the University of Pennsylvania Medical School, graduating in 1885. This same year he started his practice in Camden, N. J.

His medical career was long and interesting. During the first few years of his practice he was the personal physician to Walt Whitman. The old, gray poet made a deep impression on the young physician, and during the remainder of his life he was active in any affair that would help to preserve the memory or works of this great American poet.

He was on the first medical staff of the Camden

Home for Friendless Children, being elected at its founding in 1885. In 1895 he was appointed physician to the West Jersey Orphanage. On January 2nd, 1895, an epidemic of diphtheria broke out in the orphanage and infected nineteen of the inmates. Upon requisition of Dr. MacAlister for antitoxin, a new remedy then coming into vogue, the Board of Trustees sent a special agent to New York to procure the blood serum from the Pasteur Institute. As soon as the remedy was obtained, Dr. MacAlister began its immediate use, stopping all other forms of treatment, and, in eighteen cases effected a cure. This was the first instance in which antitoxin treatment was used in Camden County in diphtheria cases. (See Godfrey's History, p. 143.)

DECEASED PHYSICIANS—NEW JERSEY

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
William H. Albright	72	Aug. 7, 1938	Wilson, Pa.	Alpha	Cerebral hemorrhage.
Louis Franklin	56	Dec. 20, 1938	Jersey City	Same	Chronic nephritis.
Michael S. Granelli	57	Dec. 22, 1938	Bayonne	Hoboken	Carcinoma of bladder.
Alfred E. Oakes	52	Dec. 20, 1938	Elizabeth	Elizabeth	Probable cardiac death.
Harry S. Willard	62	Dec. 11, 1938	Ridgewood	Same	Angina pectoris.

Send in your report on the survey of your private practice before February fifteenth. This report is needed in order to evaluate the services which the people of New Jersey are receiving from their physicians.

CONTACTS AND COMMENTS

THE LEGISLATURE IS NOW IN SESSION

The present legislative session is likely to become a very active one, and the members of the medical profession in New Jersey must keep in touch, through their County Society keymen, with bills of interest to the profession.

Legislative battles are won or lost back home. If your legislators will not follow the advice of the physicians in their home counties, they

will not follow ours here in Trenton. If you do not bring to the representatives in your county the medical profession's views on bills concerning its welfare, our contacts here in Trenton will avail little. You are the doctor in more ways than one. Only by team work can we win respect for our opinions.

LEROY A. WILKES.

ANNUAL REPORTS BY PRESIDENTS OF COUNTY SOCIETIES

The time is rapidly approaching when the officers and committees of The Medical Society of New Jersey will make their annual reports, and estimate the extent of their accomplishment of the objectives which were announced at the last annual meeting. The measure of these accomplishments is the response of the county societies in applying the methods proposed by their appointed representatives in the House of Delegates in June, 1938.

At the last meeting of the House of Delegates a motion was unanimously adopted that the President of each county society be requested to prepare a report of the progress made by his society during the past year. A brief outline of a plan for the report is now in preparation, and will be sent to each President in the near future in order that his record may be included in the report to be printed in the May Journal.

COUNTY SOCIETY BULLETINS

Great progress in county society administration is revealed by the monthly bulletins which they issue. These have been revelations along two lines:

1. To the members of the county societies as records of their participation in the particular activities in which they have been engaged.

2. To the officers and committees of the State Society as evidence of the wisdom and practicality of their proposals.

A prominent feature of every issue of every bulletin is an appeal to the members to coördinate their plans and activities with those of their representative officers and committeemen who serve the State Society. These appeals, coming spontaneously from the officers of the local societies, are convincing evidence of the growing participation of practicing physicians generally in medical administration and the activities of the county societies.

POST-GRADUATE INSTITUTE

The Philadelphia County Medical Society will hold its Fourth Annual Post-Graduate Institute on March 13-17, 1939, in the Bellevue Stratford Hotel, Philadelphia, Pa. (near the City Hall). The general subject will be *Blood Dyscrasias and Metabolic Disorders*, and the sub-divisions will be discussed by ninety speakers whose subjects will be practical,

such as Pernicious Anemia, Blood Transfusion, Bone Marrow Biopsy, Epistaxis, Splenectomy, Metabolism in its details, Diabetes, Pellegra, etc.

These subjects will be presented in ninety lectures by as many speakers. The sessions will begin at 9 a.m. and 2 p.m. with a dinner meeting at 7 o'clock on Wednesday.

A registration fee of five dollars will be charged

for the entire course. Physicians from New Jersey will be cordially welcomed.

For information address:

The Philadelphia County Medical Society
21st and Spruce Streets
Philadelphia, Pa.

ALUMNI ASSOCIATION

The Alumni Association of the New York University College of Medicine, New York City, will observe its annual Alumni Day on February 22, 1939.

A scientific session on *pneumonia* will be held at 10 a. m. in the 28th Street building, 477 First Avenue.

A social luncheon will be held in the Wyckoff Memorial Lounge, 338 East 26th Street, at First Avenue.

Clinic and case demonstrations will be held in the Amphitheatre Building, Bellevue Hospital, at 3 p. m. on the subject "Lung Abscess".

Graduates practicing in New Jersey will receive a cordial welcome at any of the features of the program.

ASSOCIATION OF MILITARY SURGEONS

A meeting of the New Jersey Chapter of the Association of Military Surgeons will be held in the Academy of Medicine of Northern New Jersey, Newark, on the evening of Thursday, February 23, 1939, at 8:30 p. m. The speaker of the evening will be Dr. Henry H. Kessler, of Newark, Technical Adviser to the Committee on Industrial Injuries and Occupational Diseases of The Medical Society of New Jersey, who will speak on crippling conditions with special reference to muscles.

The meeting will be preceded by an informal dinner at 7 o'clock at the Hotel Douglas, 15 Hill Street.

Expected guests are Major General Charles R. Reynolds, the Surgeon General, U. S. Army, and Major General H. L. Gilchrist, U. S. Army, Ret., Secretary of the National Association of Military Surgeons.

JEFFERSON MEDICAL COLLEGE ADDRESS

Major General Merritte W. Ireland, U. S. A., retired, who was Surgeon General of the Army during the World War, will deliver the annual William Potter Memorial Lecture in the Assembly Hall of the Jefferson Medical College, 1025 Walnut Street, Philadelphia, on the evening of Thursday, February 23, at 8:30 p. m., on the subject "Medicine's Debt to the U. S. Army".

Physicians generally are invited.

The William Potter Memorial Lectures are given once a year in honor of the man who served as President of the College Board of Trustees for twenty-nine years. Mr. Potter was one of Philadelphia's most distinguished and honored citizens, participating actively in civic, educational, religious, and business affairs.

MEDICAL HISTORY

The preliminary investigation of the sources of Medical History of New Jersey is approaching completion, and will soon be ready for distribution to

the county societies. It is proposed that the history will be based on the official records of the State Society, and those of the county societies. Most of the activities of the State Society began with tentative suggestions by individual leaders, followed by investigations by committees of the State Society, and approaches to legislators. Next came action by the local county societies, and finally by the enactment of laws that were simple in their scope, with a growing complexity as the new activities developed.

One great objective of the proposed history is to learn more about the personalities of the leaders in these movements. Their biographies are best obtained by the county societies of which the State leaders were members. In this work the help of the county societies is essential.

A comprehensive plan of conducting the historical investigations is in process of preparation and will soon be ready for the use of the county societies.

A. M. A. FILMS

The American Medical Association has a number of motion picture films for loan, among which are several on *physical therapy*. The borrower is expected to pay the expense both ways and is expected to be careful when running them.

The new subjects available are:

- Aids in Muscle Training
- Occupational Therapy
- Underwater Exercises
- Massage
- Contraction of Arteries
- Effects of Heat and Cold and of Massage on the Circulation
- Treatment of Compression Fractures of the First Lumbar Vertebra

These films may be obtained as loans from the American Medical Association, 535 N. Dearborn Street, Chicago, Ill.

INFANTILE PARALYSIS RELIEF

About 150 persons met on January 16 to consider forming a County Branch of the National Foundation for Infantile Paralysis, which is promoted by President Roosevelt. The meeting was held in Bergen Pines, the County Sanatorium, which was established as the result of the infantile paralysis epidemic of 1918. The Superintendent, Dr. Joseph R. Morrow, presided. The new organization proposes to raise a fund through dues of ten cents per member.

ADOPTION OF CHILDREN

The laws of New Jersey require certain procedures to be followed in adopting children. A fundamental procedure is the determination whether a child or a family should enter into an adoptive relation. The Department of Institutions and Agencies stands ready to advise any doctor or other person regarding the examinations to be required of both the child and the home of the person applying for permission to adopt the child. A compilation of the laws relating to the procedure may be obtained from the Department. These laws are designed to protect both the child and the foster parents.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

FEBRUARY, 1939

7 Camden	10 Atlantic
7 Hudson	10 Salem
8 Mercer	14 Bergen
8 Ocean	14 Cumberland
9 Burlington	15 Middlesex
9 Essex	16 Gloucester
9 Passaic	16 Morris
9 Somerset	22 Monmouth

MARCH, 1939

7 Camden	10 Atlantic
7 Hudson	10 Salem
8 Mercer	14 Bergen
8 Ocean	15 Middlesex
8 Union	16 Gloucester
9 Burlington	16 Morris
9 Essex	22 Monmouth
9 Passaic	

ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held at the Ambassador Hotel, December 9, 1938, the President, Dr. James H. Mason, presiding. Seventy-eight members and guests were present.

One application for admission to membership was received.

PROCEDURES BY VISITING NURSES

A letter from the Visiting Nurses Association requesting the instruction of the County Society for the carrying out of certain procedures is to be replied to by the Public Health Committee, Dr. D. W. Scanlon, Chairman.

FARM SECURITY ADMINISTRATION

A motion was made and passed that the Executive Committee of this Society work in conjunction with the Farm Security Administration. (Journ., 1938, p. 684.)

TUBERCULIN TESTING

The President appointed a committee composed of one member of each of the following standing committees: Legislative, Medical Economics, Publicity, Public Health, and Tuberculosis. This committee is to study the problem of tuberculin-testing children in Atlantic City and County.

SCIENTIFIC

In the scientific program, Dr. John B. Flick, Clinical Professor of Surgery, Jefferson Medical College, gave an address on "Surgical Treatment of Pulmonary Tuberculosis".

Dr. B. S. Pollack, Medical Director of Hudson County Tuberculosis Hospital, spoke on "The State Society Plan for Tuberculosis Control in School Children". He outlined the work that is carried on in Hudson County, and urged the Atlantic County

Medical Society to adopt a plan for carrying out a similar program here.

The papers were discussed by Drs. Irvin, Allman, Fish, Marvel, Hudson, Lucas, Barbash, Harris, Salasin, Carrington, and Read.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held December 6th, 1938, at 9 p.m., at the City Dispensary Building, President H. Wesley Jack presiding.

SCIENTIFIC

Lt.-Col. Albert G. Hulett, Medical Reserve, United States Army, gave a short talk on professional preparedness.

At the request of the President, Dr. Maldies introduced the guest speaker of the evening, Dr. William Seaman Bainbridge, who spoke on "The Cancer Problem of Today". The talk was illustrated with lantern slides.

The discussion was opened by Dr. W. Wayne Babcock (by invitation), followed by Dr. Goldstein, and closed by Dr. Bainbridge.

Dr. Jack introduced Dr. Carrington, President of the State Society, who in a short, spirited talk praised the County Society for the activity and interest in State affairs. He suggested official action on Assembly Bill 511, and talked briefly on the medical health program. He stated that voluntary health insurance was probably better than compulsory. If the Society so desired, a committee could be appointed to try this as an experiment in this county.

NEW MEMBERS

Drs. Gerald W. Husted, C. Frazier Hadley, Jr.; Milton H. Gordon and J. Harvey Dempsey, recently elected members, took the oath of membership and were introduced to the Society.

The survey of medical services includes that of your own practice. Send your individual report before February 15.

The following men were elected to active membership after second reading of the applications:

Bascom S. Waugh, M.D., 1878 S. Tenth Street,
Camden

Kirk Robert Deibert, M.D., 159 Elm Avenue,
Woodlynne

Joseph Newmeyer, M.D., 701 Broadway, Camden

G. Frank Santor, M.D., 3176 Westfield Avenue,
Camden

The regular meeting of the *Camden County Medical Society* was held January 3rd, 1939, at 9 p. m. Dr. H. Wesley Jack, President, presided, and 130 members and guests were present.

SCIENTIFIC

The speaker of the evening was Dr. Frank Lahey, of Boston, Director of The Lahey Clinic and Surgeon to the New England Deaconess and New England Baptist Hospitals. The large number of guests and members were amply repaid for their attendance with a masterly discussion on thyroid disease. The lecture was illustrated with slides.

CONSTITUTION

The Business Committee presented proposed changes to the Constitution which will be acted upon at the next meeting.

NEW MEMBERS

The following men were elected to active membership:

B. H. Smith, M.D., 315 King's Highway, Audubon

Paul A. Ironsides, M.D., 571 Benson Street,
Camden

William C. Williams, M.D., Black Horse Pike,
Haddon Heights

MEMORIAL

A memorial to Dr. Alexander MacAlister was adopted. (See page 134.)

CAPE MAY COUNTY

Warren D. Robbins, M.D., Reporter

A special meeting of the *Cape May County Medical Society* was held on Friday, January 13, 1939, at 9 p. m., in the Bellevue Hotel, Cape May Court House.

PNEUMONIA PROGRAM

The program, sponsored by Dr. Samuel Hughes and Dr. Samuel Gidding of Wildwood, was devoted entirely to the subject of *pneumonia*, and presented through the courtesy of the New Jersey State Department of Health.

The speaker, Dr. Harvey Doe, discussed the pneumonia situation in our State, and outlined the facilities offered by the State, in typing sputum and supplying serum. The address was illustrated with projection films on pneumonia, sponsored by the State Department of Health.

Attendance was small due to a heavy snowfall. Members present were: Drs. Tomlin, Dandois, Cryder, Brooks, F. Hughes, S. Hughes, Gidding and Jennings, and Mr. D. C. Bowen, District health officer.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The first meeting of the *Cumberland County Medical Society* under the newly adopted plan of monthly meetings was held at Bridgeton Hospital, in the Board Room, Tuesday evening, January 3rd, at 9 o'clock.

MATERNAL MORTALITY

Dr. J. Franklin Reeves, Bridgeton, read a paper on "The Maternal Mortality in Cumberland County". There were five deaths, making a percentage below that of the average State maternal mortality rate.

The cause of each death was determined as nearly as possible, and the various means used to anticipate any untoward results.

An initial examination in detail at the beginning will not suffice for the whole term. It should be advertised widely that a blood test is required when the patient first presents herself to the doctor. This is a most beneficent measure and will prevent the transmission of syphilis to the child and thus eventually eradicate this devitalizing disease.

A frequent review of maternal mortality, such as presented by Dr. Reeves is most helpful to keep the subject fresh in the public mind.

HALLOA, 1939!

Nineteen thirty-nine, we greet you
On Life's highway stretching past;
Never feet have trod its pavement,
Faith and Hope our guides at last.

"Forward, March!" your order shows us.
Minds alert must keep your pace;
Gates ajar now inward beckon
Us to enter in your race.

We may make the way more easy,
Helping others bear their load;
If our own to bear we weaken,
They will help us on the road.

If we meet dejected spirits,
We can show a face of cheer
That will light the heavy-hearted,
And will help them banish fear.

We can feed the hungry traveler,
Though there's little we can spare;—
Giving half brings satisfaction,
Making up for what we share.

As we reach each daily milepost,
Nightly rest will sweeter be;
And the morrow find us grasping
Each new opportunity.

—E. S. CORSON.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

A monthly meeting of the *Essex County Medical Society* was held at the Academy of Medicine, Thursday, December 8th, 1939, at 9 p. m., President David Kraker presiding.

The society passed a resolution similar to the one passed in the County Dental Society, protesting against the treatment of Catholics, Jews, and Protestants in Germany.

SCIENTIFIC

Dr. Kraker introduced Colonel J. W. Grissinger, Surgeon, 2nd Corps Area, U. S. Army. He, in plain, simple language, told how unprepared the United States was at the time of entering the World War. He stressed the importance of trained officers in the Medical Corps. He said you could train a soldier in less than six months but not an officer. He spoke on the large number of casualties in gas warfare in the past, and he felt that it was in this field that most of the wars of the future would be fought. He cited the shortage of equipment and urged that all take more interest in the army of our country.

Captain Charles H. Oman, Senior Medical Officer, 3rd Naval District, stressed the importance of military training for the physician. He gave those present an idea what an officer in the Navy does by illustrating happenings in his own life while in the U. S. Naval Service.

NEW MEMBERS

The following were elected to active membership:

George Gamsu, Newark
Clifford B. Matthews, Newark
Fred Sachs, Nutley
S. L. Spenner, Newark

To associate membership:

David B. Fisher, Millburn
George P. Koeck, Newark

The Regular Monthly Meeting of the *Essex County Medical Society* was held at the Academy of Medicine in Newark on January 12th at 9 p. m. President Dr. David Kraker was in the chair. Dr. LeRoy A. Wilkes, Executive Officer of the State Society, and his executive assistant, Dr. Norman M. Scott were present.

Semi-Annual Reports were given by all committees.

PUBLIC HEALTH

Dr. Charles M. Robbins who has taken over the chairmanship of the Public Health Committee has followed closely the plans laid down by the late Dr. Theodor Teimer. Dr. Robbins announced that the Society has obtained Dr. Russel Cecil to talk on Pneumonia at the Academy of Medicine on Thursday, February 9th, at 8:45 p. m. At the same meeting Dr. Edgar A. Lawrence will speak on Chemo Therapy; and Dr. Arthur L. Fischberg will discuss the heart.

PUBLIC RELATIONS

Dr. Royal A. Schaaf gave an extensive report on Public Relations Committee activities. The speakers, the radio programs, the specialists' advice group, and the newspaper articles would all help to put the physician in a better light with the public, and let the people know that the Doctor is working for their interest and benefit and not for selfish purposes. It will help to obtain and hold the good will of the people.

NEWSPAPER ARTICLES

Dr. Stuart Z. Hawkes, chairman of the subcommittee on newspaper articles gave a lengthy report of what he and his members were doing. He stated a series of articles have been written which will appear in the Newark Evening News each Saturday under the general title "The Story of Modern Medicine". The articles are written by the members of the County Medical Society, and will cover the history of interesting developments in medicine, current problems, and possibly a discussion of some unsolved medical topics. The object behind these writings is to acquaint the public with the development of modern medicine and show the part the medical man has played in bettering civilization through medical advancements.

He added that any suggestions from any County or State Society member as to content or future context of the articles would be well considered and greatly appreciated.

THE COUNTY BULLETIN

Dr. Henry A. Davidson reported on the Essex County Medical Society Bulletin. He said the Bulletin should be the medium by which members of the Society should acquaint one another with their thoughts and ideas.

The Bulletin is now financially self-supporting through its advertising.

LEGISLATIVE

Drs. E. Zeh Hawkes and Roy Van Ness spoke on Bill Number 511. It was much discussed by many present, and finally a motion was made and passed that we uphold the action of the Council asking and instructing our representatives in the committee to have certain changes made in those sections referring to corporate practice and changing the wording referring to incorporated educational institutions.

NEW MEMBERS

The following physicians were elected to membership:

Active—

Bruning, Richard H., Maplewood
Chernus, Jack, Newark
Crapanzano, Domenico, Essex County Hospital
Ginsberg, Leon, Essex County Hospital
Hatcher, George A., Essex County Hospital
Rich, W. E., Essex County Hospital
Schneider, Leo, Newark
Sena, Marie A., Newark
Tilton, William R., Newark
Wurzel, Milton, Newark

Reinstatements—

Cheskin, Louis J., Newark
Schachter, Harry A. H., Newark
Washington, William H., Newark

Associate—

Einhorn, Samuel, Newark

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

SECTION MEETINGS FOR MARCH

Council Thurs, March 2
Obstetrics and Gynecology Thurs., March 2
Eye, Ear, Nose and Throat Mon., March 13
Medicine and Pediatrics Tues., March 14
Stated Meeting, 28th Anniversary. Thurs., March 16

PROGRAMS OF SECTIONS

Obstetrics and Gynecology—Thursday, March 2

Symposium on Obstetrical Care—

"Pre-natal Care", James F. Norton, M.D., Attending Obstetrician, Margaret Hague Maternity Hospital, Jersey City.

"Care During First Stage of Labor", Arthur W. Bingham, M.D., Senior Attending Obstetrician, Orange Memorial Hospital, Orange.

"Care During Second Stage of Labor", Walter B. Mount, M.D., Attending Obstetrician, Mountainside Hospital, Montclair

"Care During Third Stage of Labor", John F. Condon, M.D., Attending Obstetrician, Newark City Hospital, Newark.

"Post Partum Care", Robert A. MacKenzie, M.D., Attending Obstetrician, Monmouth Memorial Hospital, Long Branch.

Eye, Ear, Nose and Throat—Monday, March 13—

"Diabetic Changes of the Eye", Samuel Schulsinger, M.D.

Medicine and Pediatrics—Tuesday, March 14—

"Foci of Infection in Arthritis with Special Reference to the Teeth and Tonsils", D. Murray Angevine, M.D., Cornell University Medical College. Discussion opened by John W. Gray, M.D.

Stated Meeting—28th Anniversary—

"Our Uncontrollable Governor—the Pituitary Gland", Oscar Riddle, M.D., Carnegie Institution, Washington, D. C.

All meetings are open to the general profession and to medical students.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held on Thursday evening, January 19, at the Homestead Coffee Shop, with the President, Dr. William Crain, of Woodbury, presiding, and thirty-four members present.

Reports were made by the delegates to the various county medical societies.

BOARD OF MEDICAL EXAMINERS

The names of Drs. Diverty, Pedrick and Wood were approved by the society for presentation to

the Board of Trustees of The Medical Society of New Jersey for the Board of Medical Examiners of New Jersey.

NEW MEMBER

Dr. Benjamin Broselow, of Franklinville, was elected to membership.

PUBLIC RELATIONS

The Public Relations Committee reported that it is making plans for speakers to appear before various groups in the county.

PUBLIC HEALTH

The Public Health Committee reported that the Gloucester County Health Association was planning to proceed with the testing and x-raying of high school pupils and teachers for tuberculosis.

SCIENTIFIC

The Committee on Scientific Program presented Dr. Thomas M. Kain, of Camden, a member of the Pneumonia Control Committee of the State Medical Society, who spoke on the treatment of pneumonia. His remarks were chiefly directed toward the use of specific serum in the treatment of the disease.

After his remarks, several motion pictures depicting the treatment of the disease by the use of serum were shown.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular monthly meeting of the *Hudson County Medical Society* was held on Tuesday, January 3, 1939, at the Carteret Club, Jersey City, and was called to order by the President, Dr. Reeve L. Ballinger, at 9:25 p. m.

SCIENTIFIC

Dr. Ballinger introduced Dr. Cary Eggleston, Assistant Professor of Clinical Medicine at Cornell University Medical College, Assistant Visiting Physician to Bellevue Hospital, and Assistant Visiting Physician to New York Hospital, who spoke on the subject "The Use of Digitalis and Diuretics in Heart Disease". Discussors: Drs. T. White, Ginsberg, Ben-Asher, Jaffin, Yudkoff, D'Acerno, L. Pyle, Pearlstein, Swiegel (Essex County), Kun, Nalitt, and Leir. Discussion terminated by Dr. Eggleston.

HONORARY MEMBERSHIP

Resignations from Drs. John Connell, Daniel S. Hardenberg and Donald Miner were accepted and they were unanimously elected to Honorary Membership in the Hudson County Medical Society, under Chapter 1, Section 1 (b):

"Honorary Membership shall apply to such members who are proposed to the Society, upon recommendation of the Executive Committee. Such membership will have no vote in the Society, nor will they be eligible to hold any office whatsoever in the Society. They will pay no dues, either to the County Medical Society or to the State Medical Society. Other than this, these members will be

subject to any and all rules of the Society. Their only exclusion as to obligation to the Society will be the non-payment of dues, and their inability to vote or hold office."

JUDICIAL COUNCILOR'S REPORT

Dr. V. P. Butler, Councilor for the Second Judicial District of The Medical Society of New Jersey, in reporting concerning the Second Judicial Councilor's Meeting which was held December 15, 1938, at St. Peter's auditorium, thanked Dr. N. M. Alter for the very comprehensive and practical report which appeared in the January Bulletin.

Dr. Butler was given a vote of thanks by the County Society for the very able way in which he conducted this meeting.

LEGISLATIVE COMMITTEE

Dr. B. S. Pollak, Chairman of the Legislative Committee of The Medical Society of New Jersey, asked the Hudson County Medical Society to favor the reintroduction of Assembly Bill 511, which is known as the Uniform Medical Practice Act. Dr. Pollak made the motion; it was seconded by Dr. P. D'Acerno and unanimously voted in favor of the reintroduction of this bill, which Dr. Pollak stated has been approved by seventeen of the twenty-one component medical societies in this State.

PUBLICATION COMMITTEE

Dr. N. M. Alter stated that they are endeavoring to increase the income of the Bulletin by selling advertisements, and that it is very successful.

MEDICAL ECONOMICS COMMITTEE

Dr. J. L. Evans has asked Dr. Fred Elliott, who is Chairman of the Medical Economics Committee of the New York State Medical Society, to be our guest speaker at the February meeting.

Dr. Evans further reported that the medical survey was completed and that he would have a copy of it for the Secretary within a few days.

CANCER COMMITTEE

Dr. R. L. Ballinger stated that two weeks ago he attended a meeting of the State Cancer Committee, and there was a great deal of discussion about the new program put on by the government, inasmuch as there are about eleven grams of radium that the government is going to loan out to hospitals practically free of charge, with the exception of paying insurance. He stated that is the intent, but it will depend on the rest of the program by the Federal Government.

DINNER COMMITTEE

Dr. J. F. Norton: "The Dinner Committee has decided to hold the Annual Dinner of the County Society February 1, 1939, at the Carteret Club. This dinner is informal, and the tickets are \$2.50 per person. It has also been decided that \$2.00 of this \$2.50 will be used for the dinner. The entertainment will be high-class. We are having two very capable and interesting speakers. Practically every doctor in the County Society will be contacted within two or three weeks."

MIDDLESEX COUNTY

Louis R. Panigrosso, M.D., Reporter

The annual dinner-meeting of the *Middlesex County Medical Society* was held at the Rogers Smith Hotel in New Brunswick, N. J., December 21st, 1938, Dr. J. V. Smith, President, presiding.

SCIENTIFIC

Dr. Irving E. Fink, Flight Surgeon for the airlines, Newark, N. J., gave a very interesting talk on "Aviation Medicine" and the "Flight Surgeon". He was followed by Mr. William Hinton, First Pilot of American Airlines, who gave a very interesting talk on "Pilot's" work in commercial aviation today. Miss Evelyn Brennerman, hostess of T.W.A., spoke on "Duties of Airline Hostess".

MEMBERSHIP

Dr. Siegal was reinstated a member of the society, and four applications for associate membership were received.

LEGISLATIVE

Dr. J. Mann presented a synopsis of Bill A-511, after which he moved that the Society approve the said bill. Motion seconded by Dr. Howley. Motion passed.

VENEREAL DISEASE COMMITTEE

Dr. Samuel E. Kramer presented the following report of the Committee on Venereal Diseases:

An effort has been made to bring the indigent venereal problem of Perth Amboy into harmony with the national program for the control of venereal diseases. This entails an organized method for the treatment of indigent cases by doctors who are interested and trained in the care of venereal cases.

1. Because of the opposition of the medical profession of Perth Amboy to public clinics of any type, the committee recommends an arrangement for the care of indigent venereal cases in the offices of specified physicians.

2. Two hours a week shall be set aside in the offices of these physicians for care of venereal cases.

3. The number of physicians to be appointed shall depend on the load of patients. Recommendations for appointment shall be made by the Venereal Disease Committee of the County Medical Society.

4. It is suggested that one physician shall care for a minimum load of twenty visits per week, and a maximum of thirty.

5. It is recommended that the arrangement shall begin with the appointment of two men, and that the number of men participating shall be increased as soon as the average load can be determined.

6. It is recommended that the first two appointments shall be the two practicing urologists of Perth Amboy, who shall guide new appointees in the latest venereal practices.

7. It is recommended that the County Medical Society indorse the qualifications of venerealogists—as required by the State Bureau for the control of Venereal Diseases.

8. It is recommended that physicians accepting compensation for such venereal care shall not accept general relief patients and relief compensation.

9. The compensation for such venereologist shall be derived from State funds to the sum of \$2.50 per hour, and additional funds from city sources of at least an equal amount.

This report was placed on file.

Dr. Rothschild requested again that election of officers take place in May instead of December. Request put on file.

CANCER COMMITTEE

Dr. Edward Klein, Chairman, distributed pamphlets entitled "Facts Concerning X-Ray and Radium in Treatment of Cancer".

PUBLIC RELATIONS COMMITTEE

Dr. Joseph H. Kler submitted the following report of the Committee on Public Relations.

During the last year an attempt has been made to integrate the work of the County Public Relations Committee with that of the Public Relations Committee of the State Medical Society, so that the programs of the parent and component societies will dovetail rather than overlap.

Since September, 1938, not less than thirty medical speakers have been supplied by the committee for meetings of lay groups.

The editorial acceptance of the weekly health feature "The M.D. Says:" by newspapers of the county has been gratifying. In the month of November five different newspapers in the county published it with fair regularity. Two of these papers, the New Brunswick Daily Home News, and the Perth Amboy Evening News, are papers of large circulation.

Committees of physicians have been created in each community in the county in which there is a library to advise with the librarian concerning medical literature presented to lay readers.

The survey of the need and supply of the medical services in Middlesex County has been conducted by the committee.

The recommendations of the committee are briefly these:

1. Continue established public relations program.
2. Complete the medical survey under way.
3. The committee recommends that the newspaper advertising program proposed by the State Society's Committee on Public Relations be approved and inaugurated in Middlesex County.
4. The committee recommends that a formal letter of appreciation be sent to the South River Pharmacy and to Schwartz's Pharmacy, Highland Park, and Ford's Pharmacy for their very dignified advertising of the medical profession.

NOMINATION OF OFFICERS

On recommendation of the Nominating Committee, the following officers were elected:

Dr. N. N. Förney, of Milltown, President

Dr. B. F. Slobodien, of Perth Amboy, Vice-President

Dr. Estelle Kleiber, New Brunswick, Secretary
Dr. Marshall Smith, New Brunswick, Treasurer
Dr. Howard E. Dieker, South River, Reporter.

The following are delegates to the State Medical Society: Dr. H. Hayward, Dr. J. V. Smith and Dr. J. F. Weber; alternates, Dr. P. S. Abrey, Dr. John Rowland, and Dr. Adrian Urbanski.

Dr. J. V. Smith was named a delegate to the State Nominating Committee; alternate, Dr. Hayward.

INSTALLATION OF PRESIDENT

The retiring President, Dr. J. V. Smith, thanked the Society and the officers for their splendid cooperation throughout his administration. He then introduced the new President, Dr. N. N. Förney, who in his speech of welcome requested the same measure of cooperation be given him as was given by the members to previous administration.

On motion of Dr. Rothschild a rising vote of thanks was given to our retiring President, Dr. J. V. Smith.

Meeting adjourned 11:30 p.m.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held at the Nurses' Home, Fitkin Memorial Hospital, Neptune, N. J., on December 21st, 1938. The meeting was called to order promptly at nine o'clock by the President, Dr. C. B. Blaisdell, of Long Branch. The meeting was well attended and devoted to the economic aspect and the problems of the profession.

PAID MEDICAL ADVERTISING

Dr. James A. Fisher, Asbury Park, Chairman of the Public Relations Committee, discussed the desirability of following the suggested program of Dr. Kler, chairman of the same committee of the State Society. It was the consensus of opinion that, while this program might be a highly desirable one, to institute a paid advertising campaign at this time might leave with the lay-public an impression that the medical profession was seriously concerned with the spectre of state medicine.

Dr. W. G. Herrman, Asbury Park, speaking on the subject, felt somewhat opposed to the proposed program and stated that it was of doubtful value and that whatever good might be accomplished would be offset by the unjustifiable antagonism of the public press, who were more or less governed by those who are unfriendly toward organized medicine. * * * If not the newspapers themselves, then the attitude of those who advertise extensively. It was his personal feeling that much more could be accomplished by the doctors talking to the lay groups and societies. * * * Also by improving the relationships to the public and the public welfare organizations—such as we have done in Monmouth County.

MEMBERSHIP

One application for membership was received and referred to the Board of Censors.

LEGISLATION

Dr. W. G. Herrman, Asbury Park, was the main speaker of the evening. He discussed "Medical Practice Bill A-511", also known as the "Medical Practice Act". He explained in detail its five provisions, and strongly stressed the fact that provisions required the applicants to practice medicine in this State to first become citizens of the United States before they are permitted to take the examinations. After considerable discussion, it was moved by Dr. Robert McKenzie, Asbury Park, that this act be endorsed by our Society, and that its adoption by the State Society be pushed immediately and vigorously. This was seconded by Dr. Moffat, and was unanimously adopted by the Society.

OLD-AGE PENSIONS

Dr. Samuel Hausman, Red Bank, then discoursed on the status of the old-age pensioners—particularly as related to the medical care and regulations. He stated that in Monmouth County nigh one-half million dollars is spent annually in the care of 2,000 old-aged individuals on relief, about \$19.00 being allotted per person under care. Medical fees allowed coincide almost exactly with those under the auspices of the emergency relief regulations. He emphasized the cordial relationship and coöperation going on between the Welfare Board and the County Society. One discordant feature, however, is the existing lack of provision made for the payment of medical fees during the last month of a pensioner's life. However, he stated that further negotiations are going on to finally adjust this in favor of the attending physician.

CONTRACT PRACTICE

Dr. Harvey Brown, Freehold, reported for the *Board of Censors* in the matter of several contracts of the members of our society under advisement. His report was that no agreement or decision among the members of the committee could be reached because of the fact that an ethical contract, as it would apply to Monmouth County, had not yet been clearly defined. Dr. Harold Kazzman, Long Branch, who had been designated by the President of this society to assist this committee, reported what the State of New York Medical Society described as an ethical contract. The criticism was that this was too expansive and general to be applied to the problem as it exists in Monmouth County.

Following this the meeting was adjourned at about 11:30 o'clock to partake of a collation which was provided by the hosts of the meeting, Dr. J. Clark, and Dr. O. R. Holters, Asbury Park.

ECONOMIC COMMITTEE

A meeting of the Economic Committee was held on December 6th in the Staff Library of the Fitkin Memorial Hospital, Neptune, with Dr. O. R. Holters, Chairman, presiding. Those attending were Drs. Holters, Haines, Blaisdell, Freedman, and Woronoff.

It was decided that the committee should place before the next meeting of the County Society, after some discussion, the desirability of amending our constitution to state that any applicant for

membership in the society shall be first a citizen of the United States.

After a thorough discussion, it was also decided to introduce a motion that the County Society favor establishing a central office somewhere in the county, and also to employ a full-time executive to coördinate all the various activities of committees and members. The reason for this is that with the progress of medicine so rapidly advancing, and the many social and economic activities on the part of the Federal and the State governments, it is no longer possible for one man, or individuals, in the profession to cope with the requirements as the present situation demands.

It was also decided to bring up for discussion and possible adoption, a resolution of expanding the present monthly "Bulletin". It was the consensus of opinion of those present that a highly ethical program of advertising contained in the "Bulletin" would not only pay for the cost of publication, but would also provide for the suggested expansion.

Dr. Blaisdell also read a detailed report of the close and sympathetic coöperation that the Welfare Board has given us, particularly in the consideration in fees derived from the care of wards of the State Board of Children's Guardians and those in the old-age pension group.

CANCER COMMITTEE

A meeting of the *Cancer Committee* of the Monmouth County Medical Society was held on December 5th at nine o'clock in the evening at the offices of the Chairman, Dr. O. R. Holters, Asbury Park. Those attending were Drs. Holters, W. G. Herrman, Carlos Pons, Franklin Wilbur, all of Asbury Park, and Harold Kazzman, Long Branch, and Frank Miele, Keansburg.

It was the consensus of opinion of those present that the proper diagnoses and treatment of malignant tumors require the combined efforts of the radiologist, pathologist, internist, surgeon, and specialists of various kinds.

It is recommended that the County Society approve a resolution asking the chief of staff and the board of medicine of several of our county hospitals to consider the establishment of diagnostic and treatment clinics.

Recognizing the enormous expense and expenditure of effort in creation of a tumor group, careful consideration should be given that this is not overdone. In other words, perhaps for the best effect, no more than two groups should be formed.

Consideration was given the formation of an *auxiliary lay organization* to secure funds, and also provide the necessary lay personnel in the management of such a venture.

It was discussed that the program of the January meeting of the County Society be entirely devoted to cancer. Dr. Herrman will be the main speaker of the evening, and discussion will follow by Dr. Pons and others.

It is recommended that any doctor in the county who is to do x-ray or radiology work under the auspices of the County Medical Society should be recognized and endorsed by one of the various societies—such as the American Board of Radiology, etc.

EXECUTIVE COMMITTEE

A meeting of the Executive Committee was held at the Monmouth Memorial Hospital, Long Branch, December 5th, Monday evening. The meeting was called to order by the President, Dr. C. B. Blaisdell, Long Branch. Members of the committee who were present were Drs. Blaisdell, Albright, K. G. Brown, Clark, Matthews, Moffat, Hausman, and Featherston.

Communications were read and ordered filed.

It was decided by the Executive Committee that because of the holiday season the December meeting should be held on the 21st instead of the 28th. It was also decided that the annual dinner should be held in April, and that the December meeting would be a regular meeting with the usual scientific and business sessions.

Dr. Blaisdell and Dr. Moffat reported on a recent meeting of the State Welfare Committee which was held in Trenton. A discussion took place at that time in regard to the resubmission of the Medical Practice Bill to the Legislature. Apparently the State Legislative Committee is undecided what course to follow, and it was suggested a member of this committee appear before the county medical societies to explain the bill and to obtain the different opinions. The Executive Committee felt that because of Dr. Herrman's close connection with the situation last year, he could assume this duty for the Monmouth County, and thereby save some member of the State committee a trip to our next meeting.

The Secretary-Treasurer reported that the final returns had just been received for the 1938 President's Birthday Infantile Paralysis Party and that the chairman of the local committee had turned over to the Monmouth County Medical Society a check for \$400.71, which has been deposited in the special checking account.

OLD-AGE ASSISTANCE COMMITTEE

A meeting of the Special Committee on Adjustment of Public Charges of the Monmouth County Medical Society, together with Mr. John L. Montgomery, Director of Welfare; Mrs. Margaret E. Thompson, Deputy County Director; Miss Evelyn T. Walker, County Advisory Nurse; and Miss Mae Boone, Health Supervisor, was held on November 28th, 1938, at the office of the Bureau of Old Age Assistance 125 Pearl Street, Red Bank, N. J.

The following physicians were present: Drs. Samuel Hausman, Chairman; C. Byron Blaisdell, President, Monmouth County Medical Society; Samuel Edelson, J. C. Clark, William Matthews, Howard C. Peiper.

The following decisions were reached by the committee and will be presented to the Medical Society in the near future:

1. The fee for an office visit shall not exceed \$1.00. When it is necessary to render first-aid treatment and the doctor feels that an additional charge should be made, his bill will be submitted to the Special Committee for their approval before it is presented to the Welfare Board.

2. The fee for anti-luetic treatment in the doctor's office shall be \$1.00. (Biologicals are furnished free of charge by the State Department of Health on request.)

3. The fee of \$1.50 may be charged by a specialist of urology in his office for catheterization.

4. Eye specialist's fee shall be \$3.00 for refraction. Glasses are not to be furnished by the specialists.

5. When two examinations are required for eye refractions, the specialists are to obtain authorization from this office for the second visit. Before authorization can be given, these cases are referred to the Special Committee for approval and then presented to the Welfare Board.

6. After the first visit is made, the doctor or the patient is to notify this office or the public health nurse in the district within forty-eight hours.

7. In cases of acute illness in which hospitalization is advisable, the patient should be admitted to the hospital rather than be treated at home. This is not only desirable because of the patient's welfare, but it is to the advantage of the physician as well. The average subsistence grant is \$19.86, and the maximum grant which can be allowed one recipient in one month is \$30.00. Therefore, if many visits are made, it is often impossible to allow the recipient sufficient funds to pay the doctor.

8. No additional charge can be made for medicine if it is furnished by the physician. This is to be included in his regular fee of \$1.00 for an office visit, and \$2.00 for a home visit.

9. When it is necessary for a doctor to travel an unusual distance to visit a patient, any additional charges for this are to be referred to the committee as the need arises.

10. When more than one patient is seen in the same home at the same time, \$2.00 is to be charged for the home visit to one patient, and \$1.00 for each additional patient seen.

11. If two patients from the same home visit the doctor's office, and are both seen by the doctor, it is to be regarded as two office visits.

12. Prescriptions for medicine are to be marked "O. A. A." in order to obtain lower prices from the pharmacists. Dr. Hausman offered to obtain a pharmaceutical list which we will present to the pharmacists, requesting that standard prices for drugs be quoted the Bureau of Old Age Assistance.

13. It was agreed that each physician would send to the Bureau of Old Age Assistance, 125 Pearl Street, Red Bank, by the tenth of each month, a form bill for each recipient seen by him, showing dates of visits at home or in the office, diagnosis, medicine ordered, and fee. The Bureau of Old Age Assistance will then notify the doctor that the recipient will receive increase for all medical care and the date upon which recipient will receive same. No bills over one month old can be allowed. Form bills are to be supplied by Old Age Assistance. When recipients or their relatives are expected to meet the cost of medical care without an increase in the grant, the doctors will be notified.

14. In view of the fact that \$30.00 is the maximum, it is not always possible to allow the full amount required for medical care in the one check,

and allowances are sometimes made over a period of several months before the doctor's bill can be audited. The doctor will be notified when this arrangement is necessary.

It was agreed by the committee that, when a doctor has an account receivable, it is up to him to collect it. In the event that the recipients do not pay the doctors after the doctors have been notified that the recipient has been allowed an increase in his assistance for this purpose, the doctors have agreed to notify this office within one month that they have not been paid.

It was also suggested that a separate list of O. A. A. patients be kept in the doctor's office, both for his own convenience and for reference in case any communication is necessary with the O. A. A. office.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular meeting of the *Morris County Medical Society* was held the evening of January 19 at the State Hospital at Greystone Park, with President Thomas presiding.

A resolution of condolence was passed on the death of the mother of Dr. Costello.

Several members suggested that the Maternal Welfare meetings be changed to an evening that would not conflict with the meetings of the County Medical Society.

NEW MEMBERS

Three new members were elected: Dr. John Stewart Forbest, of Basking Ridge; Dr. Edward M. Smith, of Madison; and Dr. Harry B. McCluskey, of Whippany.

BABY KEEP-WELL STATION

The Executive Committee recommended the appointment of Dr. Truax to the Baby Keep-Well Station at Boonton. Objection to these stations was raised because they treat babies where the care by private physicians can be afforded.

ADVERTISING BY THE COUNTY SOCIETY

The matter of advertising in newspapers in the county was brought up and a letter from the Chairman of the Public Relations Committee of the State Society read, urging the County Society to conduct an advertising campaign in favor of sustaining the institution of the private practice of medicine. Favorable action was taken on this report; and it was decided that a report of the probable cost be given at the next meeting.

DRUG STORE CLINIC

It was reported that a cut-rate drug store was contemplating the opening of a clinic in Whippany, and that the services of two physicians were to be obtained to treat patients for fifty cents a patient, the drugs to be furnished by the store. This matter was called to the attention of the State Medical Society and the State Pharmaceutical Society. The two doctors who had been mentioned denied that they had made any such contract.

SPRING GOLF TOURNAMENT

The Spring Golf Tournament of the Society was discussed, and it was decided not to solicit prizes from the local business men, but that the Society purchase two cups not to exceed in cost \$30 to be offered as awards in the contest.

WELFARE COMMITTEE

Dr. Sherman reported on a meeting of the State Welfare Committee, that Essex County was in favor of omitting the clause in the proposed bill which would allow corporations to designate who would treat their employees, and expressed the belief that the bill would be improved by this revision.

BOARD OF MEDICAL EXAMINERS

The Society took action endorsing Dr. Elmer P. Weigel for appointment to the State Board of Medical Examiners.

SCIENTIFIC

Dr. Elmer P. Weigel, of Plainfield, was the guest speaker of the evening and gave a very interesting talk on "Osteogenic Sarcoma", which was illustrated by lantern slides and x-ray films. Dr. Weigel's presentation was discussed freely.

The meeting closed with a social period, with refreshments in the hospital cafeteria.

OCEAN COUNTY

J. Bruce Henriksen, M.D., Reporter

The regular monthly meeting of the *Ocean County Medical Society* was held at the Paul Kimball Hospital, Lakewood, at 9 p.m., December 14, 1938, with President Emanuel Sickel presiding. Those present were Drs. Buermann, Bunnell, Dodd, Frazee, Gaumer, Herbener, Henriksen, McIlvaine, Menge, Obert, Sickel, Szold, Taylor, Thompson, Tilles, Towbin, and Witte.

SCIENTIFIC

Under the auspices of the New Jersey State Department of Health two reels of interesting motion pictures depicting the treatment of syphilis were shown. Then Dr. Casselman and Dr. Burgison each gave interesting talks on the treatment of syphilis.

LEGISLATION

Dr. William J. Carrington, President of our State Society, spoke to us on the advisability of again sponsoring Bill A-511 in the coming Legislature. He outlined the provisions of the bill and answered questions pertaining to it. Dr. Towbin moved, Dr. Bunnell seconded, and it was carried that the Ocean County Medical Society go on record as favoring the passage of this bill.

The *Ocean County Medical Society* held its regular monthly meeting at the Paul Kimball Hospital at 9 p.m., January 11, 1939, with the President, Dr. Emanuel Sickel, presiding. Those present were Drs. Bunnell, Carmona, Dodd, Frazee, Gaumer, Goldstein, Halbach, Herbener, Henriksen, Ivory, Menge, Obert, Sickel, Szold, Towbin, and Davies.

SCIENTIFIC

Dr. Sickel gave an interesting talk on conditions which may be mistaken for a coronary thrombosis, and illustrated his remarks by a number of x-ray films. Diverticulum of the esophagus was especially stressed.

Dr. Towbin discussed various phases of coronary artery disease and recommended the liberal use of morphine in acute cases. Further discussion was led by Drs. Goldstein, Bunnell, Herbener, Carmona, and others.

PRACTICE WITHOUT LICENSE

It was moved by Dr. Adolph Towbin and seconded by Dr. Gaumer that the Secretary be instructed to write to the New Jersey State Board of Medical Examiners in order to ascertain whether patients were being treated at the Lakewood Inhalatorium without a licensed physician in attendance.

LADIES' NIGHT

Dr. Halbach moved, and Dr. Menge seconded, that the annual "Ladies' Night" be held as usual this year. Motion carried. Dr. Towbin requested hearty coöperation of the members in order that the affair might be a complete success.

HOME FOR AGED

It was regularly moved and seconded that the Society go on record as favoring the establishment of a home for the aged in Ocean County. Motion carried.

HOSPITAL STANDING

It was regularly moved, seconded, and carried that the Chair appoint a committee to review the facilities of the Royal Pines Hospital, and to make recommendations to the Society as to its fitness to be recognized in the Register of the American Medical Association. The Chair appointed Drs. Halbach, Bunnell, and Carmona as that committee.

ANNUAL BULLETIN

It was moved by Dr. Dodd and seconded by Dr. Bunnell that the Society authorize the Secretary to issue an annual bulletin for the Society. Motion carried.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on January 12, 1939, at the Woman's Club, Paterson, Dr. Louis G. Shapiro presiding.

NEW MEMBERS

Dr. Frank B. Vanderbeek, Paterson, was elected to active membership; and Dr. Anthony L. Espósito, Clifton, to associate.

Six applications for membership were received.

CENSORS

The report of the Board of Censors by Dr. MacMillan found that charges preferred against a physician were sustained, and recommended a vote of

censure by the Society. This was approved by the members present.

HISTORY OF COUNTY SOCIETY

A communication from Dr. Frank Overton, Editor of the State Journal, was read requesting the appointment of a committee to write the history of the Passaic County Medical Society. This appointment was authorized, and the following were appointed: Kenneth E. McCamey, Chairman; E. J. Marsh, Fred Vosburgh.

MEDICAL INSURANCE

Dr. Christopher Beling, Chairman of the Committee on Medical Defense of the State Society, spoke on accident and health insurance; and Mr. Heard of the firm of Faulhaber and Heard, Inc., and Mr. William Blankenstein spoke briefly on the various policies approved by the State Society.

SCIENTIFIC

The scientific program was as follows:

Dr. Bret Ratner, Clinical Professor of Pediatrics, New York University College of Medicine. "Abdominal and Digestive Manifestations of Allergy in Children."

Dr. Marion B. Sulzberger, Assistant Clinical Professor of Dermatology and Syphilology, New York Skin and Cancer Unit of the Post-Graduate Medical School and Hospital, Columbia University, "Allergic Skin Diseases in Children".

A large, appreciative audience heard these papers with great interest.

The following memorial was adopted (see January Journal, p. 52):

By the passing of Dr. Willard, his patients have lost a skillful adviser and a sympathetic friend, the medical profession a careful and competent ophthalmologist and consultant, and this Society a loyal and useful member; but with the sorrow we feel at this separation there comes also the cherished memory of a valued friendship, and the inspiration of a high example.

FRANCIS H. TODD,

ELIAS J. MARSH,

M. B. PARK,

Memorial Committee.

SALEM COUNTY

REPORT OF THE SALEM COUNTY SOCIAL
DISEASE CLINICS FOR 1938

To the Board of Chosen Freeholders of the County of Salem, N. J.:

As in the past four years, five weekly clinics were held this year, three in the clinic rooms in the Salem County Memorial Hospital, and two in the rooms in the Old Moose Hall in Pennsgrove furnished by the Common Council of the Borough of Pennsgrove. In the Spring of this year the Pennsgrove clinic was moved into rooms adjacent to the ones previously occupied and which were arranged so as to be much better suited for the work. Six hundred and twenty-four hours of phy-

sicians' time were spent in the clinics, which were held regularly regardless of holidays.

In the Pennsgrove clinic there were 29 new cases of syphilis admitted; an average of 96 cases per month were under treatment; 3,562 treatments for syphilis, and a total of 3,740 clinic treatments were given.

In the Salem Clinic 21 new cases of syphilis were admitted; an average of 58 cases were under treatment monthly; 2,089 treatments for syphilis and a total of 2,675 treatments were administered to clinic patients.

Thus in county clinics, there were 50 new cases of syphilis admitted; an average of 154 cases were treated monthly; and a total of 7,065 treatments were administered, including 650 treatments given at the Salem County Home.

For the past four-year period, new cases of syphilis have been as follows:

1935	125
1936	74
1937	27
1938	50
<hr/>	
	276

The increase in the number of new cases of syphilis admitted to the clinic is not in fresh infections, but is due to the detection of old and hidden cases which have been found on routine examinations of the blood and subsequent study of the patients and their families. In many instances the infections date back ten to forty years. It is relatively very rare at the present time to find cases which have been only recently infected, and such cases are usually found to have been contracted from some source outside the State or county.

A survey of the work of the clinics made for the State Department of Health during the week of December 5th to December 11th showed the following division of cases and the number under treatment:

PENNSGROVE CLINIC

Syphilis

White male	21	White female	3
Colored male	41	Colored female	14

Gonorrhoea

White male	2	White female	1
Colored male	6	Colored female	2

SALEM CLINIC

Syphilis

White male	19	White female	1
Colored male	37	Colored female	17

Gonorrhoea

White male	1	White female	1
Colored male	1	Colored female	1

The total number of cases of syphilis under the observation and treatment of the County Clinician for that week was 178.

The passage of two laws at the last session of the Legislature has been of great value in forwarding control work on these diseases in this State: First, the law requiring a blood test prior to issuance of a marriage license; and, second, the law requiring a blood test on all pregnant women. These laws should do much to prevent family degeneracy from familial infection with syphilis.

The results of the clinic work will become more apparent as time goes on. At the present time we may call attention to the fact that the homicide rate in the county for 1935 and 1936 was 16 per hundred thousand; a rate about three times that for the State of New Jersey, which was 5 per 100,000 in 1935. This year, 1938, the rate in the county has been only 3 per hundred thousand. Ultimately expenditures in this work will be compensated for by a reduction in costs for the care of the insane, feeble-minded, pauper and criminal.

For the year 1939, in addition to the budget of \$3,000.00 which has been set aside by the Board of Chosen Freeholders for the upkeep of the clinics, the State Department of Health will allow certain additional funds from the State Welfare allowance which may be used to supplement the salaries of the physicians working in the county clinics. This fund will allow an increase of about \$250.00 a year for Dr. Church and Dr. Mason, and enable a salary of \$500.00 a year to be established for Dr. H. F. Suter, who for the previous five years has served as a voluntary assistant without pay. These allowances from the State funds will also cover quite a considerable part of the clinic drug bill, and are granted upon the assurance that the county is already using a similar or larger amount, and that the county appropriation will not be curtailed or supplanted by the State fund allowance.

FRANKLIN H. CHURCH.
December 29, 1938.

UNION COUNTY

Ronald J. Walsh, M.D., Reporter

The regular meeting of the *Union County Medical Society* was held at the Elizabeth General Hospital on January 11th, 1939. Dr. Henri Abel presided.

SCIENTIFIC

Dr. Edward H. Dennen, Attending Obstetrician to the New York Polyclinic Medical School and Hospital, addressed the Society on "Choice of Instruments in Delivering with Forceps". Dr. Dennen's presentation was clear and detailed. He described the different positions requiring forceps intervention, and the practice best suited to the occasion. He explained the principles upon which different types of forceps are constructed, and the factors which indicated which type should be selected in individual cases.

Unfortunately the motion-picture part of his discussion was unavailable because of camera difficulties, but Dr. Dennen's paper was highly interesting.

PUBLIC HEALTH NURSING

Dr. Alice Gibb proposed the curtailing of the tendency of the public health nurses towards a too

lavish solicitude for the public weal, and further proposed that these nurses should be instructed to visit the private patients of physicians only upon request of the physicians concerned. The problem was referred to the Public Health Committee for study and report.

MANTOUX TESTING

Dr. John E. Runnels spoke of the increased Mantoux testing in the county, and expressed himself as perturbed at the mounting cost of this service. During 1938 the sum of \$17,000 had been spent. He feared that the Board of Freeholders might object to such a large or larger expenditure for this year, and suggested that some reduction in medical cost be effected. The fee basis in use is fifty cents per examination, and three dollars per roentgenographic study. The use of paper plates instead of the usual film was mentioned, but unfortunately there was not a roentgenologist present to discuss the advisability of this course. Dr. Carl Kapp opposed the reduction of the fee standard until it would be shown that such a reduction was necessary. The matter was shifted to the Public Health Committee for study and report.

SECRETARY TO THE MEDICAL SERVICE BUREAU

The President announced that Dr. Catherine Falconer had been appointed from a group of applicants to the position of full-time secretary to the Medical Service Bureau. Dr. Falconer is a graduate of Wellesley and is an M.D. from Cornell. She will shortly take up her duties, and will try to visit all the members of the Society to ascertain their views and intentions concerning the Bureau.

The resignation of Dr. William F. Turner from the Society was received and accepted.

NEW MEMBERS

The following physicians were elected to membership:

Dr. Frank Glassner, 308 Chestnut St., Roselle
Dr. James H. Maroney, 129 Summit St., Summit
Graham C. Newbury, 208 Holly St., Cranford
Jerome M. Wolff, 1414 Martine Ave., Plainfield.

SUMMIT MEDICAL SOCIETY

The December meeting of the *Summit Medical Society* was held at the Nurses' Home of Overlook Hospital on Tuesday evening, December 27th.

The meeting was called to order by the President, Dr. Hallock, with twenty-three members and eight guests present.

Dr. Toufick Nicola, of Montclair and New York,

spoke on "Orthopedic Problems of General Interest" and also the shoulder operation which bears his name. This was illustrated by numerous slides and models. There was a general discussion of this interesting presentation. (See page 73.)

Following the meeting a collation was served.

SOCIETY OF SURGEONS OF NEW JERSEY

Walter B. Mount, M.D., Secretary

The Annual Meeting of the *Society of Surgeons of New Jersey* was held on Saturday, January 28th, 1939, in Newark. Morning clinics were held at St. Michael's Hospital and at the Newark Eye and Ear Infirmary.

At St. Michael's Hospital eight operations were performed by members of the society. Demonstrations and presentations of cases were given by five members of the society. At the Newark Eye and Ear Infirmary operations were performed by two members of the society and five other members of the hospital staff.

Luncheon was held at the Robert Treat Hotel, and eighty-five members and guests were present. Six movies of operations were shown in the afternoon. The dinner was attended by 129 members and guests.

At the business meeting preceding the dinner the following officers were elected:

President, Dr. Irvin E. Deibert, Camden
First Vice-President, Dr. Edward W. Sprague, Newark
Second Vice-President, Dr. Milton A. Shangle, Elizabeth
Secretary, Dr. Walter B. Mount, Montclair
Treasurer, Dr. Christopher A. Brokaw, Elizabeth

Members of the Executive Committee:

Dr. Herbert W. Nafey, New Brunswick
Dr. Charles H. deT. Shivers, Atlantic City
Dr. William J. Sweeney, Weehawken

The following new members were elected:

Dr. Edmund J. Daly, Jersey City
Dr. Thomas S. P. Fitch, Plainfield
Dr. Daniel J. Geary, Morristown
Dr. J. Wallace Hurff, Newark
Dr. John S. Irvin, Atlantic City
Dr. James H. Lowrey, Newark
Dr. Robert A. MacKenzie, Asbury Park
Dr. Spencer T. Snedecor, Hackensack
Dr. Isadore Stein, Elizabeth
Dr. Harrison B. Wilson, Hackensack

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CONSTITUTION AND BY-LAWS OF THE MEDICAL SOCIETY OF NEW JERSEY

As Amended up to the Close of the Annual Meeting, May 19, 1938

Constitution

ARTICLE I—NAME

The name of this organization is "The Medical Society of New Jersey".

ARTICLE II—PURPOSE

The purposes of this society are:

- To federate and organize the medical profession of the State of New Jersey;
- To unite with similar organizations of other states to compose the American Medical Association;
- To advance medical science, elevate professional standards, safe-guard the material interest of and promote friendly relations among members of the medical profession;
- To educate the public in prevention of disease and the preservation of health; and, in general,
- To render this profession most capable of serving humanity.

ARTICLE III—COMPONENT SOCIETIES

County medical societies that hold charters from this society shall be known, and referred to in the Constitution and By-Laws, as *component societies*.

ARTICLE IV—COMPOSITION OF THE SOCIETY

SECTION 1—OF WHOM COMPOSED

This society shall be composed of Fellows, Officers, Delegates, and members of Component Societies in good standing.

SECTION 2—GROUPS

(a) *Fellows*. The Fellows are the Ex-Presidents of the society.

(b) *Officers*. The Officers shall be a President, a President-Elect, two Vice-Presidents, a Secretary, a Treasurer, members of the Board of Trustees, and the Councilors.

(c) *Delegates*. Delegates shall be chosen by and from the component societies, and shall be members of this society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society continuing in good standing in this society.

SECTION 3—ELECTION OF DELEGATES

(a) *Apportionment*. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at its annual meeting by a majority ballot of the members present; but, each component society shall be entitled to at least three (3) delegates. Each component society shall, at its annual meeting next following the adoption of this Constitution, elect delegates in 3 groups, for periods of 1, 2, and 3 years, respectively; and thereafter shall elect its delegates for periods of 3 years each.

(b) *Reapportionment*. In the event of subdivision of any of the existing counties of New Jersey and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided, and the quota of the original component society of that district shall be correspondingly diminished.

(c) *Delinquency*. In the event that a component society becomes delinquent to this society, its entire delegation shall lose its status throughout the period of such delinquency.

(d) *Vacancies*. A vacancy shall exist in the delegation of any component society whenever one of its delegates ceases to be in good standing, or fails to attend two consecutive meetings (annual or special) except in case of illness, or resigns, or dies. When such a vacancy occurs in any component society, its

secretary shall promptly so notify the secretary of this society, in writing; and, after acknowledgment of receipt of such notice, the component society shall, at a regular or special meeting, fill the unexpired term of such vacancy by election of a new delegate, by a majority ballot of the members present.

(e) *Alternates.* Each component society shall elect, at its annual meeting, an alternate delegate for each regular delegate, and the latter, if unable to attend the annual meeting (or any regularly called meeting) of this society, shall assign his delegate's card to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate; and, when registered and seated in the House of Delegates, shall retain his seat during that entire meeting.

SECTION 4—MEMBERS OF COMPONENT SOCIETIES

All members of component societies in good standing are hereby constituted members of this society and entitled to participate in all the privileges of general and scientific sessions.

SECTION 5—HONORARY MEMBERS

Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, and who may be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen (15). They shall have all the privileges of members, but shall not be members of the corporate body.

SECTION 6—GUESTS

Any physician, resident or non-resident of New Jersey, may, upon invitation of this society or its House of Delegates, become a Guest during the annual meeting, and shall thereby be accorded the full privileges of the scientific sessions.

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the *legislative* body, and shall consist of the Fellows, Officers and Delegates.

ARTICLE VI—BOARD OF TRUSTEES

The Board of Trustees shall be the *executive* body, and shall be composed of the President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least

two (2) from each judicial district—who shall be elected as follows:

At the first election of officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.

ARTICLE VII—COUNCILORS

The House of Delegates shall organize five (5) councilor districts within the state. This society shall elect one (1) councilor from among the delegates of each such district; and these elected councilors, collectively, shall constitute the Judicial Council.

ARTICLE VIII—MEETINGS

SECTION 1—GENERAL SESSION

This society shall hold an annual meeting, during which there shall be at least one general session that shall be open to all registered members.

SECTION 2—SECTIONS

The House of Delegates or the Board of Trustees may provide for division of the scientific work of the society into appropriate sections whenever necessity therefor arises.

SECTION 3—TIME AND PLACE OF ANNUAL MEETING

The time and place for said annual meeting shall be fixed by the House of Delegates for each succeeding year. The Board of Trustees may change the time and place when necessary.

ARTICLE IX—OFFICERS

SECTION 1—TERM OF OFFICE

The Officers, except the Councilors and members of the Board of Trustees, shall hold office for one year, or until their successors are elected and installed.

SECTION 2—ELECTION

The Officers shall be elected by this society, by ballot on the second day of the annual meeting. No member shall be eligible to more than one office at the same time, except the President, President-Elect and two (2) Vice-Presidents, Secretary and Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled *ad interim* by the Board of Trustees.

ARTICLE X—FUNDS AND EXPENSES

SECTION 1—FINANCES

Current expenses of this society shall be met by an annual *per capita* assessment upon the members of each component society; by donation; by sale of the society publications; and from miscellaneous revenue. During the annual meeting, funds may be appropriated by the House of Delegates for the expenses of the annual meeting, for publications, for expenses of officers and committees, but for no other purpose, unless authorized by a two-thirds vote of the members of the House of Delegates then present, and approved by the Board of Trustees.

SECTION 2—INCURRING EXPENSE

The Board of Trustees may incur any necessary expense *ad interim*.

ARTICLE XI—SEAL

The seal heretofore adopted and now in use shall continue, unless otherwise ordered, to be the Seal of the Medical Society of New Jersey.



Seal of the Medical Society
of New Jersey

ARTICLE XII—AMENDMENTS

This Constitution may be amended by a two-thirds vote of the members present at any annual meeting, provided the proposed amendments have been considered by the Committee on Revision of Constitution and By-Laws, and that they shall have been submitted in writing at a previous annual meeting, shall have been published in the Journal of this society, and officially sent to each component society at least three (3) months before the annual meeting at which final action is to be taken.

By-Laws

CHAPTER I—MEMBERSHIP

SECTION 1—PERSONNEL

The Fellows and Officers of and all the elected delegates to the Medical Society of New Jersey and the members of component societies in good standing are members of this society. Honorary members are entitled to the rights given them by the Constitution.

SECTION 2—OFFICIAL LIST OF MEMBERS

(a) March fifteenth in each year is the final date for closing the official list of members. Five days before this date the treasurer of each component society shall forward to the treasurer of this society a complete list in duplicate of all paid-up members in good standing, with their correct addresses, at the same time remitting the assessment covering such membership. The Trustees shall arrange for the compiling and publication of the Official list from the lists so received by the treasurer.

(b) On the fifteenth day of March in each year, the secretary of each component society shall send to the secretary of this society the

following information: names of the officers, reporter and censors, member of the nominating committee, delegates and alternates to this society, complete list of associate members, the preceding year. Where members have members elected, deceased, and those who have resigned or moved from the county during transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

(c) Upon request of the Secretary, the secretary of each component society shall furnish complete lists of the names of all affiliated and non-affiliated physicians resident in the county.

(d) The Official List as published each year shall be *prima facie* evidence of the right of members to register at the annual meeting, and, unless otherwise ordered by the House of Delegates, shall form the basis of representation of each component society.

SECTION 3—INELIGIBILITY

No person who is under sentence of suspension or expulsion from any component society, or whose name has been dropped from its roster shall be entitled to any of the rights

or privileges of this society, nor shall he be permitted to take any part in any of its proceedings, until relieved of such disability.

SECTION 4—REGISTRATION AT ANNUAL MEETING

All members and delegates in attendance at the annual meeting of this society shall write their names and addresses on an official registration card which shall be duly presented at the registration desk; failing to do so, they shall be considered as absent.

SECTION 5—CREDENTIALS

(a) All delegates shall present to the Committee on Credentials a certificate, bearing the seal of this society and the signature of its secretary. No delegate will be permitted to register or sit as a member of the House of Delegates without such certificate, nor if the component society of which he is a delegate has not paid its annual assessment.

(b) The annual assessment of a component society shall be the dues of at least the smallest number to whom a charter may be granted to form a component society, in accordance with Chapter X, Section 2, of these By-Laws.

SECTION 6—BADGE

When a member's right to membership has been verified by the Committee on Credentials, he shall receive a certificate or badge which will be evidence of his right to the privileges of membership. No member or delegate shall be permitted to take part in the proceedings of this society until the provisions of this chapter have been fulfilled.

CHAPTER II—MEETINGS

SECTION 1—ANNUAL MEETING

This society shall hold an annual meeting at such time and place as may be fixed by the House of Delegates or by the Board of Trustees.

SECTION 2—SPECIAL MEETINGS

Special meetings of this society or of the House of Delegates shall be called by the President upon the petition of twenty or more members representing four or more component societies, or upon request of the Board of Trustees.

CHAPTER III—CONDUCTING THE SESSIONS

SECTION 1

All registered members may attend and participate in the proceedings and discussions of the general and section meetings. The general

meetings shall be for the presentation of the addresses of the President and President-Elect, orations by invited guests, and scientific papers and discussions as provided for in the official program; these meetings shall be presided over by the President, President-Elect or one of the Vice-Presidents. Special section meetings shall be for the presentation of scientific papers and discussions related to the medical or surgical specialty designated and as provided for in the program; these section meetings shall be under the guidance of a presiding officer chosen by each section at its last session of the preceding annual meeting.

SECTION 2—COMMITTEES

The general and section meetings may create committees for scientific investigations of special interest or importance to the profession or public, and may receive and dispose of such committee reports; but no expense shall be incurred in connection therewith until authorized by the House of Delegates and approved by the Board of Trustees.

SECTION 3—PROGRAMS

The order of exercises, papers and discussions, as set forth in the official program, shall be followed from day to day until completed; unless otherwise ordered by the society.

SECTION 4—LENGTH OF ADDRESSES

No address or paper, with the exception of those delivered by the President, President-Elect, and invited orators, shall occupy more than twenty minutes in its delivery or reading; and no member shall speak longer than five minutes, nor more than once, on any subject, unless by permission of the society.

SECTION 5—OWNERSHIP OF PAPERS

All papers and reports presented to the society shall become its property, and when read shall be deposited with the Secretary. Permission to publish such papers in the Journal of the society or in other medical journals may be granted by the Committee on Publication.

CHAPTER IV—HOUSE OF DELEGATES

SECTION 1—MEETINGS

The House of Delegates shall meet on the first day of the annual meeting of the society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general meetings of the society.

SECTION 2—QUORUM

Twenty members, representing at least four component societies in good standing, shall constitute a quorum. Sessions of the House of Delegates shall be open to all members of the society, but only members of the House of Delegates shall have the right of voice or vote.

SECTION 3—CHARTERS

It may issue charters to county societies applying for affiliation with this society.

SECTION 4—AUTHORITY OVER COMPONENT SOCIETIES

It shall consider the reports of component societies, and have authority to make such recommendations and adopt such measures as may be deemed effective for building up and increasing the interest of these societies.

SECTION 5—APPEALS

It shall hear and finally determine all appeals taken from decisions of the Judicial Council.

SECTION 6—FINAL AUTHORITY

The House of Delegates or Board of Trustees must approve all memorials and resolutions issued in the name of the society before they can become effective.

SECTION 7—BUSINESS DURING THE LAST SESSION

Unanimous consent shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or the Committee on Finance. All new business so presented shall require a three-fourths affirmative vote for adoption.

CHAPTER V—SELECTION OF OFFICERS

SECTION 1—NOMINATING COMMITTEE

Each component society shall elect at its annual meeting one of its elected delegates to serve as a member of the Nominating Committee of this society, and one of its elected delegates alternate thereto; this elected member, or his alternate, shall present his credentials to the Secretary at the close of the first session of the annual meeting. The Junior Past-President of this society shall be the member of the Nominating Committee representing the Fellows; if he shall not be able to serve, then at the close of the first session of

the annual meeting the Fellows shall elect one of their number to be a member of the Nominating Committee, who shall forthwith present his credentials to the Secretary. The delegates, or their alternates so elected from their respective component societies, and the representative of the Fellows, shall compose the Nominating Committee. This committee shall meet at 8.30 p. m. on the first day of the annual meeting and report the result of its deliberations to the House of Delegates in the form of a ticket containing nominations for each of the offices to be filled, including Trustees, Standing Committees, Councilors, Delegates to the American Medical Association and to other medical organizations.

SECTION 2—PROCEDURE

(a) The Chairman of the Nominating Committee shall be the Junior Past-President of the society or the member elected by the Fellows. The committee shall elect one of its own members to serve as secretary and to call the roll of accredited members of the committee as certified by the Secretary of the society. Nominations for all offices, standing committees, delegates to the American Medical Association and other medical organizations, shall be made by individual alphabetic roll call of the counties, the representative from the Fellows being called last. The representative of each county, when its name is called, may place in nomination a candidate, second a nomination, or waive its privilege to another county. The representative of the county so favored may then nominate a candidate or second a nomination, after which the roll call will be continued from the point where it was interrupted. The representative of the Fellows may nominate a candidate or second a nomination, and shall have a vote equal to the vote of a representative of a component society. The secretary shall announce the result on the completion of each call; and if the tabulation of any roll call be challenged, the roll will again be called. A majority vote of the members present shall nominate; and in the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped and the call of the roll shall be repeated until a nomination is made.

(b) The Secretary of the society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all officers, committees and delegates to be nominated.

(c) Nothing in this section is to be con-

strued as preventing the nomination and election of Fellows to the Board of Trustees.

(d) The election of Trustees shall conform to the provisions of Article VI of the Constitution.

(e) The chairman shall read to the committee this section of the By-Laws (Section 2, Chapter V) before proceeding to any other business.

SECTION 3—TIME OF REPORT

The report of the Nominating Committee, and the election of officers, standing committees, delegates to the American Medical Association and other medical organizations, shall be the first order of business of the society in the afternoon of the second day of the annual meeting.

SECTION 4—NOMINATIONS FROM THE FLOOR

Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the society; except that the President-Elect shall succeed to the office of President without process of nomination and election.

SECTION 5—MANNER OF VOTING

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

SECTION 6—BEGINNING OF TERM OF OFFICE

Officers and members of elected standing committees shall assume office immediately after adjournment of the annual meeting at which they were elected.

CHAPTER VI—DUTIES OF OFFICERS

SECTION 1—PRESIDENT

The President shall preside at all meetings of this society and of the House of Delegates. He shall appoint all committees not otherwise provided for, and shall be ex-officio member of all standing committees except the Nominating Committee. He shall deliver an address at the annual meeting of this society, and shall perform such other duties as custom and parliamentary usage may require.

SECTION 2—PRESIDENT-ELECT AND VICE-PRESIDENTS

The President-Elect and the Vice-Presidents shall assist the President in the discharge of his duties, and in his absence or disability the President-Elect, or the ranking Vice-President shall preside at all meetings of the society and of the House of Delegates, and perform all the duties pertaining to the office. In case of vacancy in the office of President by death, resignation, or removal, the President-Elect, and in his absence, the ranking Vice-President shall perform all duties pertaining to that office until the vacancy is filled by appointment of the Board of Trustees.

SECTION 3—SECRETARY

The Secretary of the Society shall have the custody of the Constitution and By-Laws of the Society and of the records of the Society and the House of Delegates, under the direction of the Board of Trustees. He shall attend all meetings of the Society and of the House of Delegates, and shall keep a record of their proceedings. He shall give notice of all general and special meetings of the House of Delegates or of the Society, to the members of the said House or Society. He shall notify Honorary Members of their election.

He shall require and receive from the Secretaries of the County Societies a list of their representatives in the House of Delegates and the Nominating Committee, and shall publish such lists at such times and in such manner as the House of Delegates may direct.

He shall have the sole custody of the Official Seal of the Society and shall affix the same to such correspondence or instruments as the By-Laws may require or the Trustees or the President may direct.

He shall conduct such formal official correspondence in the corporate name of the Society as the Trustees or the President may direct. The Board of Trustees shall make suitable provision for the detail and clerical work of the Secretary.

He shall submit annually to the House of Delegates a report of the work of his office, and shall furnish to the Board of Trustees or to the President, upon request, such information as may be necessary for the Society's business, and shall perform such other functions as are specified in these By-Laws.

He shall be entitled to necessary expense in attending meetings or otherwise incurred in the transaction of the Society's business, as authorized by the Trustees.

SECTION 4—TREASURER

The Treasurer shall give bond, at the expense of the society, in such amount as may be required by the Board of Trustees. He shall demand, receive and preserve all funds due the society, together with bequests and donations; and keep a correct list of the same, with the name of each donor. He shall not pay any money out of the treasury except on resolution of the Board of Trustees, or upon voucher of the officer or committee responsible for the expenditure, countersigned by the Chairman of the Finance Committee, and as provided in the annual budget. His accounts shall be audited by the Trustees at such times as the Board or the House of Delegates may order, and he shall render at each annual meeting of the society a full statement of all transactions of his office. Whenever 90 per cent of the annual budget appropriated for any office or committee has been expended, he shall so notify the proper officer or committee chairman. He shall charge upon his books the assessment against each component society at the end of the fiscal year, collect and make proper credits for the same; and perform such other duties as may be assigned to him.

SECTION 5—BOARD OF TRUSTEES

(a) *Organization.* At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board shall organize by electing a chairman and a secretary; and the chairman shall appoint such committees as may seem necessary or desirable. Meetings shall be called by the chairman, but any four members may require the chairman to call a meeting for such time and place as shall be designated by them in writing. Members shall have at least five days advance notice of all meetings. Nine members shall constitute a quorum.

(b) *Powers.* The Board shall exercise general supervision over the affairs of the society, with authority to act for the society between annual meetings, and to perform the following functions:

To make recommendations to the House of Delegates;

To advise in the deliberations of the several standing committees;

To supervise the work of the Publication Committee and, when necessary, to appoint an editor and such other assistants as the needs of the society may require;

To determine all salaries;

To pass upon all recommendations for incurring expense, over and above that provided in the budget;

To order all necessary expenditures;

To refer and otherwise dispose of all business, properly arranged for its disposition;

To require and hold the official bond of the Treasurer and to annually audit his accounts;

To fill vacancies in all offices and elected standing committees until the next annual meeting.

In the event of a vacancy in the office of Treasurer, by death or otherwise, the Board of Trustees shall select one of its members to fill the vacancy.

(c) *Property.* It shall have authority to lease, sell, or otherwise convey or dispose of any or all property of the society, both personal and real, and to execute therefor, good and sufficient lease, deed, or other conveyance.

(d) *Finance Committee.* Three of its members shall serve on the Committee on Finance in accordance with Chapter VIII, Section 5, of these By-Laws.

(e) *Nominees to State Board of Medical Examiners.* Acting for the society, and in accordance with the statutes of this state, as vacancies occur in the State Board of Medical Examiners by reason of the expiration of term, or otherwise, of members of said Board representing this society, the Trustees shall nominate for each appointment three members of this Society, and the names of such nominees shall then be transmitted by the President of this society to the Governor of the state.

(f) *Annual Report.* It shall publish annually in the Journal of this society a report of its proceedings and recommendations, and shall render to the House of Delegates a summary of its activities.

CHAPTER VII—JUDICIAL COUNCIL

SECTION 1—ELECTION

The Councilors shall be elected as follows: At the first election of officers following the adoption of these By-Laws, two (2) members shall be elected for a period of three (3) years; two (2) members for a period of two (2) years; and one (1) for a period of one (1) year; and as the terms of these elected Councilors expire, new elections shall be for periods of three (3) years.

SECTION 2—CENSORS

The Councilors collectively, shall constitute a Board of Censors of this society known as the Judicial Council.

SECTION 3—MEETINGS

The Judicial Council shall meet on the evening before the annual meeting of the society, and subsequently at the call of the chairman or upon the petition of three of the Councilors, at such time and place as necessity or convenience require. Four members shall constitute a quorum.

SECTION 4—ETHICS AND DISCIPLINE

All questions of an ethical nature shall be referred by the House of Delegates or the Board of Trustees without discussion to the Judicial Council. It shall consider and decide all questions of discipline affecting the conduct of members. It shall consider all questions involving the rights of members, whether in relation to each other, to component societies, or to this society.

SECTION 5—APPEALS

(a) Any aggrieved member of a Component Society may appeal from the decision or action of the County Medical Society to the Judicial Council of The Medical Society of New Jersey. After ninety (90) days from the day of filing his appeal to the County Medical Society for a hearing, such aggrieved member, if he so desires, may appeal directly to the Judicial Council upon declaration that he has appealed to and been denied, or has not received, a hearing by his County Medical Society. An applicant who may have been excluded from membership in a County Medical Society may appeal from its action to the Judicial Council of the State Medical Society.

(b) The notice of appeal shall set forth in writing the name of the appellant, the name of such component society, the date and substance of the questioned decision, and shall indicate the grounds upon which such appeal is taken.

(c) Upon filing a notice of appeal, the appellant and the component society must submit to the Secretary of this society all records, minutes, letters, papers and written evidence, including a digest of all testimony whether or not stenographically reported, relative to the matter. All data so submitted shall be confidential and privileged, and made available only to the Judicial Council and its respective members. In case of an appeal being taken from the decision of the Council to the House of Delegates, all such data must then be submitted

to the House of Delegates or to a committee appointed by that body to consider the appeal.

(d) The Judicial Council shall consider any appeal on the data so submitted, and may affirm by a majority vote, modify, or reverse by a two-thirds vote of its members present and voting, the appealed decision. If, in its opinion, further evidence is desirable, the Judicial Council may summon witnesses, take such evidence in any manner it may deem proper, and render its decision by a two-thirds vote of the members present and voting; and all its decisions shall be binding unless or until reversed or modified by the House of Delegates.

CHAPTER VIII—COMMITTEES**SECTION 1—CLASSIFICATION**

There shall be Standing Committees, Reference Committees, and Special Committees.

SECTION 2—STANDING COMMITTEES

The Standing Committees shall be:

- Nominating Committee
- Committee on Finance
- Committee on Annual Meeting
- Publication
- Honorary Membership
- Welfare
- Post-Graduate Education
- Medical Defense and Insurance
- Woman's Auxiliary

and such other committees as the House of Delegates shall determine.

SECTION 3—APPOINTMENTS

Standing Committees, unless otherwise provided, shall be appointed by the President, and he shall designate the chairmen. The President shall be a member ex-officio of all the above named committees except the Nominating Committee. Unless otherwise ordered in these By-Laws, committee members shall serve for three years; provided that in committees of three members no two terms shall expire in the same year; and in committees of six members not more than two terms shall expire in the same year.

SECTION 4—NOMINATING COMMITTEE

The Nominating Committee shall be selected and shall function according to the provisions of Chapter V of these By-Laws.

SECTION 5—COMMITTEE ON FINANCE

The Committee on Finance shall consist of three members elected by and from the Board

of Trustees, and three members elected by and from the House of Delegates, and their term of office shall be for six years; provided that the term of one Trustee member shall expire every second year, and the term of one Delegate member on each alternate year. The Treasurer shall be a member ex-officio, his capacity being advisory and without vote except in case of tie. The committee shall elect its own chairman. It shall prepare a budget to be submitted to the House of Delegates at the annual meeting, and it shall control the expenditure of money by officers and committees, as provided in Chapter IX of these By-Laws. The committee is hereby authorized to require from any officer or committee any necessary fiscal information.

SECTION 6—COMMITTEE ON ANNUAL MEETING

The Committee on the Annual Meeting shall consist of five members. It shall have complete charge of all arrangements, plans and programs for the annual meeting and all details pertaining thereto. It shall provide suitable accommodations for the annual meeting, viz: for the general and section sessions, house of delegates, trustees, committees, woman's auxiliary, and exhibits. The general plans for the annual meeting shall be subject to the approval of the Board of Trustees and shall be reported to them at intervals, with a complete outline at least four months before the meeting.

This committee shall have two sub-committees, one on *scientific program* and one on *scientific exhibits*.

One member of the committee shall be designated by the chairman, with the consent of the President, as Chairman of the Sub-Committee on Scientific Program. It shall be his duty to arrange for papers, addresses and orations for the annual meeting. He shall see that the speakers are properly received at the annual meeting and that the scientific papers are delivered as scheduled. He may appoint two other men to assist him in the work of this sub-committee. The classification and number of scientific sections shall be determined by this sub-committee. The chairman and secretary of the scientific sections shall be elected by each section, but shall be responsible to the chairman of the scientific program and shall report to him.

Another member of the Committee on Annual Meeting shall be designated by the chairman, with the consent of the President, as the Chairman of the Sub-Committee on Scientific Exhibits. He may in turn designate two other members with the consent of the chairman, to act as a sub-committee on scientific exhibits.

The duty of this sub-committee shall be to prepare and arrange for all details in connection with scientific exhibits of the annual meeting.

SECTION 7—PUBLICATION COMMITTEE

The Committee on Publication shall consist of three members elected by the House of Delegates, with the Secretary an additional member ex-officio, and the Editor of the Journal sitting with the committee in an advisory capacity. It shall publish and distribute the Journal. Reports, papers, and discussions may be submitted to this committee for publication in the Journal; but the committee shall have authority to curtail or abstract, or to return to the author, such material as seems to it unsuitable for publication, with a statement of the reasons therefor.

SECTION 8—HONORARY MEMBERSHIP COMMITTEE

The Committee on Honorary Membership shall be composed of three Fellows. It shall inquire into the standing and qualifications of all nominees for honorary membership in the society, and report the same with recommendations to the House of Delegates.

SECTION 9—WELFARE COMMITTEE

The Welfare Committee shall consist of thirty-five (35) members, appointed annually, which number shall include the President and Secretary of this society, ex-officio. Each component county society shall be represented by at least one member, and candidates for such appointment may be suggested to the President by each component society. It shall keep minutes and records of its transactions. It shall have supervision over legislative matters, public health, public relations and medical practice, subject, when necessary, to direction from or approval by the Board of Trustees or the House of Delegates. To this committee shall be referred all questions of professional welfare not included in the specific work of the Judicial Council. It shall be empowered to employ a special agent or agents, and to expend such moneys as shall be approved by the Committee on Finance and the Board of Trustees. The work of this committee shall be divided into four sub-committees—public health, legislative, medical practice, and public relations. Each sub-committee shall consist of five members appointed annually and its chairman shall be appointed by the chairman of the Welfare Committee with the approval of the Presi-

dent. Special Advisory Committees, of five members each, to these committees may be formed on the approval of the Board of Trustees, and the members shall be appointed by the President.

SECTION 10—COMMITTEE ON POST-GRADUATE EDUCATION

The Committee on Post-Graduate Education shall consist of five members. It shall be the duty of this committee to provide a continuous program of post-graduate education for the members within the resources of the Society. It shall advise upon, correlate and promote all of the post-graduate activities of the special committees in coöperation with educational institutions.

SECTION 11—COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

The Committee on Medical Defense and Insurance shall consist of five members, and shall have charge of all matters pertaining to alleged malpractice of members and all other types of insurance, such as health, accident, life, and automobile, which may be recommended to the members.

It shall have the responsibility for the protection of the members and the contracts and relations with the insurance company. It shall at all times be cognizant of the financial responsibility of the insurance companies, brokers, and agents with whom it is dealing, and shall make frequent reports to the Board of Trustees and annually to the House of Delegates on these matters. It shall not enter into contracts without the approval of the Board of Trustees or the House of Delegates. It shall maintain contact with the Judicial Council and refer complaints of an ethical nature to that body.

SECTION 12—REFERENCE COMMITTEES

Immediately after the organization of the House of Delegates at each annual meeting the President shall appoint, from the members of the House, reference committees of five members each, unless otherwise provided, to serve during the session at which they are appointed. To these committees may be referred any reports, resolutions, measures, or propositions which have been presented to the House. When a matter is referred to any such committee, it shall meet forthwith, discuss the question referred, and hear debate thereon by any interested member of the society; and shall submit its recommendations at the next session of the House for action.

SECTION 13—NAMES OF REFERENCE COMMITTEES

There shall be the following Reference Committees, and any others to be created by the House of Delegates as need arises:

- (a) Credentials—to consist of one member to serve with the Secretary and the Treasurer, who are members ex-officio.
- (b) Resolutions and Memorials.
- (c) Constitution and By-Laws.
- (d) Miscellaneous Business.

SECTION 14—CONTINUANCE OF FUNCTION

On the order of the President or House of Delegates any reference committee may be created a *special* committee in order to continue, after the annual meeting, work which has been initiated but which cannot be completed during that meeting; but there shall be a strict limitation, in the order for its continuance, as to its function and term of life.

SECTION 15—SPECIAL COMMITTEES

Special committees may be created by the House of Delegates or by the Board of Trustees. They shall be appointed by the President, or the Chairman of the Board of Trustees, and their specific functions and term of life shall be clearly defined. The limitations in regard to incurring expense provided for in Chapter III, Section 2, of these By-Laws shall apply also to these committees.

SECTION 16—ADDING TO SIZE OF COMMITTEE

The President may at any time, on request of any committee, appoint additional members thereto, in order to meet unexpected or unusual demands on that committee; provided that the term of such emergency appointees shall cease with the close of the next annual meeting of the society.

CHAPTER IX—FINANCE

SECTION 1—PERMANENT FUND

(a) There is hereby established in the custody of the Treasurer a Permanent Capital Fund, to consist of any money which may come to the Medical Society of New Jersey by gift or bequest and not otherwise designated, any balance remaining unexpended at the close of the fiscal year which the Board of Trustees may direct to be added to this fund, and such other money as may from time to time be available for this purpose.

(b) This fund shall be deposited or invested by the Treasurer in such manner as is by law provided for trust funds, or as the Board of Trustees may direct. The income from such funds may be used for the general

purposes of the society, unless otherwise ordered, but the principal of the fund may be expended only for purposes of permanent value to the Medical Society of New Jersey, when so ordered by a two-thirds vote of the House of Delegates, such expenditure having previously been approved by the Board of Trustees and notice of such approval sent to the component societies at least one month in advance of the meeting of the House of Delegates at which action is taken.

SECTION 2—GENERAL FUND

(a) *Annual Assessment of Members.* On the first day of January in each year there shall be levied on each component society a *per capita* assessment on the membership of such component society, as hereinafter set forth (Par. b), to be paid to the Treasurer of the Medical Society of New Jersey not less than five days before the fifteenth of March, together with a list of the members for whom such payment is made. A similar *per capita* assessment shall be paid in the same manner immediately upon the admission or reinstatement of any such member, except that for a new member admitted after October first of any calendar year, one-quarter of the regular assessment shall be paid. Every member for whom the assessment is paid shall be listed as a subscriber to and entitled to receive the Journal.

(b) *Estimating the Assessment.* Two weeks before the annual meeting each officer and standing committee shall send to the Chairman of the Committee on Finance an estimate of the amount of money necessary for the work of his office during the next fiscal year. The Committee on Finance shall then proceed to consider and determine the amount of money to be raised, fix the *per capita* assessment to be levied on the component societies, and report its recommendations to the House of Delegates at the first session of that body. This report may then be approved, amended, or rejected by the House of Delegates, but final action on it shall not be taken before the last session of the meeting.

(c) *The Budget.* No officer or committee may spend more money than the amount allowed in the budget without approval of the Committee on Finance, which may, however, apportion to such officer or committee, on application, any unexpended balance of other items; provided that the total amount disposed of by the Finance Committee must not exceed the total amount voted by the House of Delegates, unless by special authority of the Board of Trustees.

SECTION 3—FISCAL YEAR

The fiscal year of the society shall begin on the first day of June, and the financial report of the Treasurer and of all officers and committees shall be for this period. The budget estimates and appropriations shall likewise be for the same period.

SECTION 4—SPECIAL BUDGETS

All motions and resolutions appropriating money for special purposes shall fix a definite sum, and shall state the budget account against which the expenditure is to be charged. Such resolutions must be passed by the House of Delegates and approved by the Board of Trustees.

CHAPTER X—COMPONENT SOCIETIES

SECTION 1—CHARTERS

County medical societies of this state that shall adopt the principles of organization in accord with the Constitution and By-Laws of this society may, upon application to the House of Delegates, receive a charter, and thereby become a component society in affiliation with the Medical Society of New Jersey as hereinafter provided.

SECTION 2—CONDITIONS OF CHARTERING

Charters shall be issued to county societies having at least ten members, under seal of the Medical Society of New Jersey and signed by the President and Secretary; but there shall be only one component society chartered in each county. Upon recommendation of the Board of Trustees, this society may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and By-Laws.

SECTION 3—QUALIFICATIONS OF MEMBERS

(a) *Judging Qualifications.* Each component society shall be the judge of the qualifications of its own members, subject to the right of approval of this society; but, as such societies are the only portals to this society and to the American Medical Association, it is recommended that every reputable and legally registered physician shall be deemed eligible to membership in a component society.

(b) *Biographies of New Members.* When a physician applies for membership or when an application is made to be received on transfer, the secretary of the component society shall forward his name and address to the biographic department of the American Medical Association for such information as may be on file relative to his record. Printed forms

for this purpose will be furnished by the Secretary of this society. After the adoption of these By-Laws, no new member shall be enrolled or accepted on transfer until this provision shall have been carried into effect.

(c) *Probationary and Associate Members.* Each component society, as a requisite of eligibility to active membership, may require applicants to serve a probationary period of not longer than two years in the society as *associate members*. Associate members shall have such privileges in component societies as the Constitution and By-Laws of the respective societies may provide, except the right to vote and hold office. Their dues shall be those fixed by their respective component society, plus the subscription price of the Journal as determined by the Board of Trustees.

(*Explanatory note.*—The following resolution defining courtesy members was passed by the House of Delegates, April 29, 1937: "Associate members of component societies shall be physicians who may be elected to active membership after a period of probation. All others now called associate members shall be termed *courtesy members*." Transactions, 1937, page 50.)

SECTION 4—APPEALS

Any physician who may feel aggrieved by the action of a component society in refusing him membership, or any member of a component society who has been suspended or expelled, shall have the right of appeal through his District Councilor to the Judicial Council. The powers of the Judicial Council and its method of procedure are defined in Chapter VII of these By-Laws.

SECTION 5—TRANSFERS

When a member in good standing in a component society moves to another county of this state, his name, upon request, may, by a majority vote of those present, be transferred to the roster of the component society into whose jurisdiction he moves.

SECTION 6—JURISDICTION

Any physician living on or near a county line may hold his membership in the component society most convenient for him to attend, on permission from the component society in whose jurisdiction he resides; *provided that* no physician may be a member of two component societies at the same time, nor of this society and another state society.

SECTION 7—REPORTERS

Each component society shall elect a reporter, who shall furnish the Editor with brief reports of its meetings and of items of interest concerning the society and its members, extracts of papers and interesting case reports, notice of the prevalence of contagious and other diseases in the county, and the election, removal or death of members.

CHAPTER XI—RESIGNATION OR REMOVAL OF OFFICERS

Any officer of this society may resign his office, or he may be removed therefrom by a two-thirds vote of the House of Delegates, when guilty of neglect of duty, improper conduct, or upon violation of the Constitution and By-Laws. In either or all cases the society shall fill the vacancy so made as provided for in Article IX of the Constitution, and in Chapters V and VI of the By-Laws.

CHAPTER XII—RULES OF CONDUCT

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of the members of the Medical Society of New Jersey in their relations to each other and to the public.

CHAPTER XIII—RULES OF ORDER

The deliberations of the society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order", when not in conflict with this Constitution and By-Laws, unless otherwise determined by a two-thirds vote of its respective bodies.

Chapter XIV is on the subject "Conferring the Degree of Doctor of Medicine", which may still be exercised.

CHAPTER XV—AMENDMENTS

These By-Laws may be amended at any annual meeting of the Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day.

Upon the adoption of this Constitution and these By-Laws all previous Constitutions and By-Laws are thereby repealed.

THE 173rd ANNUAL MEETING IN HADDON HALL,
ATLANTIC CITY, JUNE 6, 7 AND 8, 1939

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Tel. Orange 5-1100

THE MEDICAL SOCIETY OF NEW JERSEY

COMMITTEES,—THEIR MEMBERS AND DATES OF MEETINGS,—FOR THE YEAR BEGINNING MAY 19, 1938

WILLIAM J. CARRINGTON, Atlantic City, President and Ex-Officio Member of Each
Committee —By-Laws, Chapt. VI, Sect. 1

Adult Health Supervision

HERSCHEL STRATTON MURPHY, *Chairman* Roselle
WILLIAM HENRY VARNEY, *Vice-Chairman* Washington
EDWIN GRAFING DEWIS Interlaken
ROBERT MARTIN GRIER Pleasantville
EDWARD CAFFRON KLEIN Newark
AUGUSTUS S. KNIGHT Far Hills
ADOLPH TOWBIN Lakewood
WATSON BUDLONG MORRIS, *Consultant* Springfield

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Annual Meeting

CHARLES BUTCHER KAIGHN, *Chairman* Atlantic City
CLARENCE LADELLE ANDREWS, *Chairman*, Sub-Com. on
Scientific Program Atlantic City
ASHER YAGUDA, *Chairman*, Sub-Com. on Scientific Ex-
hibits Newark
THOMAS McGRATH BRENNOCK Jersey City
JOHN CLIFFORD CLARK Asbury Park
WILLIAM JOHN CARRINGTON, *Consultant* Atlantic City

Meetings

Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Auxiliary Medical Service

WILLIAM WALLACE MAVER, *Chairman* Jersey City
SAMUEL BARBASH, *Vice-Chairman* Atlantic City
ARTURO RAYMOND CASILLI Elizabeth
EUGENE GARFIELD HERBENER Lakewood
SIGURD WALTER JOHNSON Passaic
JEROME HOWARD SAMUEL Newark
WALTER ALBERT TAYLOR Trenton
ALFRED STAHL, *Consultant* Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Cancer Control

WILLIAM GETTIER HERRMAN, *Chairman* Asbury Park
HENRY BOYLAN ORTON, *Vice-Chairman* Newark
HAROLD STERN DAVIDSON Atlantic City
ELLWOOD EMERSON DOWNS Woodbury
JOHN BUTLER FAISON Jersey City
OTTO RUDOLPH HOLTERS Asbury Park
JOSEPH HENRY KLER New Brunswick
AUGUSTUS S. KNIGHT Far Hills
CHARLES B. WOODMAN Morristown
THOMAS BENJAMIN LEE, *Consultant* Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Child Health

STANLEY NICHOLS, *Chairman* Long Branch
WALTER BLAIR STEWART, *Vice-Chairman* Atlantic City
ARTHUR FOWLER ACKERMAN Summit
CHESTER BROWN Arlington
ERNEST GARFIELD HUMMEL Camden
IRVING OKIN Passaic
LOUIS CHARLES ROSENBERG Newark
ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Constitution and By-Laws

JAMES FRANCIS NORTON, *Chairman* Jersey City
DAVID KRAKER, *Vice-Chairman* Newark
HERBERT WILLIAM NAFÉY New Brunswick
GEORGE N. J. SOMMER Trenton
DAVID H. BARTINE ULMER Moorestown
FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.

Contract Practice

REUBEN LORE SHARP, *Chairman* Camden
L. SAMUEL SICA, *Vice-Chairman* Trenton
FRANK WILLIAM ASH Paterson
JOHN GEORGE DECKER Hasbrouck Heights
HENRY HAYWOOD New Brunswick
HARVEY THEODORE HEROLD Newark
EDWARD FREDERICK KLEIN Perth Amboy
JENNINGS HOWARD HORNBERGER, *Consultant* Roebling
ANDREW C. RUOFF Union City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Crippled Children

BABCLAY WELLINGTON MOFFAT, *Chairman* Red Bank
ELMER PETER WEIGEL, *Vice-Chairman* Plainfield
OSWALD RUDOLPH CARLANDER Camden
FREDERICK GEORGE DILGER Hackensack
WILLIAM GREENFIELD Hackensack
EMANUEL HARRISON NICKMAN Atlantic City
TOUFICK NICOLA Montclair
HERBERT WILLIAM NAFÉY, *Consultant* New Brunswick

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Finance and Budget

HARRY ROSS NORTH, <i>Chairman</i> (1939)	Trenton
HERSCHEL PETTIT (1942)	Ocean City
WELLS PHILLIPS EAGLETON (1943)	Newark
ANDREW FRANCIS MCBRIDE (1941)	Paterson
DAVID B. ALLMAN (1944)	Atlantic City
HENRY SPENCE (1940)	Jersey City
ELIAS JOSEPH MARSH, <i>Ex-Officio</i>	Paterson

Honorary Membership

LANCELOT ELY, <i>Chairman</i>	Somerville
EPHRAIM ROLAND MULFORD	Burlington
FREDERIC JAMES QUIGLEY	Union City

No meetings, work carried on by correspondence.

Hospital Relationships

SPENCER TREADWELL SNEDECOR, <i>Chairman</i>	Hackensack
WILLIAM H. A. WARNER, <i>Vice-Chairman</i>	East Orange
HENRY BRISTOL DECKER	Camden
FLORENTINE MILTON HOFFMAN	New Brunswick
CHARLES HYMAN	Atlantic City
ELTON WALLACE LANCE	Rahway
GEORGE O'HANLON	Jersey City
THOMAS KRAFFEL LEWIS, <i>Consultant</i>	Camden

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Industrial Injuries and Occupational Diseases

J. IRVING FORT, <i>Chairman</i>	Newark
LESLIE EDWIN MYATT, <i>Vice-Chairman</i>	Bridgeton
CHARLES LITWIN	Teaneck
TRAUGOTT JOHN SCHUCK	Hoboken
JAMES HERBERT SPENCE, JR.	Franklin
WILLIAM FRANCIS COSTELLO, <i>Consultant</i>	Dover
HENRY HOWARD KESSLER, <i>Technical Adviser</i> , representing Commissioner J. J. Toohey, N. J. Dept. of Labor.	Newark
ROY GRIFFITH, <i>Technical Adviser</i> , representing the Manu- facturers' Association of New Jersey	Glen Ridge

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Legislation

BERTHOLD STEINBACH POLLAK, <i>Chairman</i>	Secaucus
CHARLES HENRY MITCHELL, <i>Vice-Chairman</i>	Trenton
WENDALL JONES BURKETT	Pitman
HERBERT ROY VAN NESS	Newark
WILLIAM CRANE WILENTZ	Perth Amboy
SAMUEL ALEXANDER, <i>Consultant</i>	Park Ridge

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Others at call of Chairman

Maternal Welfare

ARTHUR WALTER BINGHAM, <i>Chairman</i>	East Orange
JOHN CARLISLE BROWN, <i>Vice-Chairman</i>	Atlantic City
SAMUEL ALLISON COSGROVE	Jersey City
GEORGE BURTON GERMAN	Camden
CARL HALLER ILL	Newark
JULIUS LEVY	Newark
ROBERT ABBE MACKENZIE	Asbury Park
WALTER BARCLAY MOUNT	Montclair
JAMES HARRIS UNDERWOOD	Woodbury
HARRISON BETTS WILSON	Hackensack
THOMAS BENJAMIN LEE, <i>Consultant</i>	Camden

Meetings

Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

January, 1939, Joint Meeting with County Ma-
ternal Committees and Field Physicians; date,
hour, and place to be selected by Chairman,
Dr. Bingham.

Medical Care of Indigent and Low-Wage Group

GEORGE WASHINGTON FITHIAN, <i>Chairman</i>	Perth Amboy
DAVID WRIGHT GREEN, <i>Vice-Chairman</i>	Salem
FRANK L. FIELD	Far Hills
DANIEL LEO HAGGERTY	Trenton
WARREN DAVID ROBBINS	Cape May
BYRON GRANT SHERMAN	Morristown
EDWARD MATHIAS ZEH HAWKES, <i>Consultant</i>	Newark

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Medical Defense and Insurance

CHRISTOPHER CHARLES BELING, <i>Chairman</i>	Newark
JOSEPH WALLACE HURFF, <i>Vice-Chairman</i>	Newark
JOHN CHARLES MCCOY	Paterson
GEORGE THOMAS TRACY	Beverly
WILLIAM CARTER WESCOTT	Atlantic City
WELLS PHILLIPS EAGLETON, <i>Consultant</i>	Newark

Meetings

Atlantic City....	May 19, 1938.....	4 p. m.
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Interim meetings at the call of Chairman

Trenton.....	Apr. 16, 1939.....	4 p. m.
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Medical Practice

DAVID BACHARACH ALLMAN, <i>Chairman</i>	Atlantic City
SPENCER TREADWELL SNEDECOR, <i>Vice-Chairman</i>	Hackensack
HARRY NOAH COMANDO	Newark
GEORGE WASHINGTON FITHIAN	Perth Amboy
JACOB IRVING FORT	Newark
WILLIAM WALLACE MAYER	Jersey City
REUBEN LORE SHARP	Camden
CHESTER ISAAC ULMER	Gibbstown
ANTHONY CHARLES ZEHNDER	Newark
THOMAS KRAFFEL LEWIS, <i>Consultant</i>	Camden

Meetings

Atlantic City....	May 19, 1938.....	4 p. m.
Trenton.....	Apr. 16, 1939.....	4 p. m.

For meeting of Advisory Committees see their
schedules

Mental Hygiene

JAMES STUART PLANT, <i>Chairman</i>	Newark
MARCUS ALBERT CURRY, <i>Vice-Chairman</i>	Greystone Park
WILLIAM COLE DAVIS	Atlantic City
BARCLAY STOKES FUHRMANN	Flemington
ALLEN GILBERT IRELAND	Trenton
EDWARD SHEAFE KRANS	Plainfield
CLARENCE MORTON TRIPPE	Ashbury Park
HERBERT WILLIAM NAFEE, <i>Consultant</i>	New Brunswick
AMBROSE DOWD, <i>Technical Adviser</i> , representing Commis- sioner Ellis, N. J. Department of Institutions and Agencies	Newark

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

One or two other meetings at call of Chairman

Nursing and Nursing Education

ANTHONY CHARLES ZEHNDER, <i>Chairman</i>	Newark
GEORGE MILTON KNOWLES, <i>Vice-Chairman</i>	Hackensack
HORACE WESLEY JACK	Camden
VICTOR KNAPP	Asbury Park
FRANK LESLIE PERRY	Woodstown
HARRY SUBIN	Atlantic City
THOMAS J. FRANCIS WALSH	Elizabeth
WELLS PHILLIPS EAGLETON, <i>Consultant</i>	Newark

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Pharmaceutical Problems

CHESTER ISAAC ULMER, *Chairman*Gibbstown
REEVE LESLIE BALLINGER, *Vice-Chairman*Arlington
JACOB JOHN MANNPerth Amboy
MERWIN LESTER HUMMELMerchantville
CHARLES JOSEPH MURNPaterson
DANIEL WOOLSEY TELLER, JR.Morristown
RALPH KING HOLLINSHED, *Consultant*Westville

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Pneumonia Control

ROBERT ANTHONY KILDUFFE, *Chairman*Atlantic City
THOMAS MICHAEL KAINCamden
HENRY PAUL DENGLERSpringfield
MARSHALL FLOWER LUMMISPitman
FREDERICK THOMAS VOSBURGHPassaic
RALPH KING HOLLINSHED, *Consultant*Westville
WILLIAM MACDONALD, *Technical Adviser*, representing
Dr. J. Lynn Mahaffey, Director N. J. Department of
HealthTrenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Post-Graduate Education

DAVID FULLER BENTLEY, *Chairman*Haddonfield
STUART ZEH HAWKES, *Vice-Chairman*Newark
ALBERT WILLIAM PIGOTTSkillman
ERNEST FRANCIS PURCELLTrenton
HAMMELL PIERCE SHIPPSDelanco
SLOAN GRIFFIN STEWARTAtlantic City
CLARENCE WILTON WAYSea Isle City
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.

Public Health

STANLEY NICHOLS, *Chairman*Long Branch
FREDERIC WILLIAM LATHROP, *Vice-Chairman*Plainfield
FRANK A. BIENIrvington
ARTHUR WALTER BINGHAMEast Orange
CHARLES BYRON BLAISDELLLong Branch
JACOB IRVING FORTNewark
ERNEST GARFIELD HUMMELCamden
ALLEN GILBERT IRELANDTrenton
ABRAHAM EZRA JAFFINJersey City
ROBERT ANTHONY KILDUFFEAtlantic City
ISAAC WARNER KNIGHTPitman
JULIUS LEVYNewark
BARCLAY WELLINGTON MOFFATAsbury Park
HERSCHEL STRATTON MURPHYRoselle
HENRY BOYLAN ORTONNewark
JAMES STUART PLANTNewark
ELBERT STETSON SHERMANNewark
*THEODOR TEIMERNewark
EDWARD MATHIAS ZEH HAWKES, *Consultant*Newark

Technical Advisers

ELLEN POTTER and EMIL FRANKEL, representing Wm. G. Ellis,
N. J. Dept. Institutions and Agencies.
HENRY HOWARD KESSLER, representing J. J. Toohey, N. J.
Dept. of Labor.
WILLIAM MACDONALD, representing Director Mahaffey, N. J.
Dept. of Health.
HOWARD DARE WHITE, representing Director Elliott, N. J.
Dept. of Public Instruction.

Meetings

Long Branch....July 10, 1938.....3 p. m.
Newark.....Sept. 7, 1938.....3 p. m.
Newark.....Oct. 5, 1938.....3 p. m.
Newark.....Nov. 2, 1938.....3 p. m.
Newark.....Dec. 7, 1938.....3 p. m.
Newark.....Jan. 4, 1939.....3 p. m.
Newark.....Feb. 1, 1939.....3 p. m.
Newark.....Mar. 1, 1939.....3 p. m.
Newark.....Apr. 5, 1939.....3 p. m.
Newark.....May 3, 1939.....3 p. m.
*Deceased.

Public Relations

JOSEPH HENRY KLER, *Chairman*New Brunswick
JOSEPH BERKELEY GORDON, *Vice-Chairman*Marlboro
GEORGE BARTON BARLOWEnglewood
EDGAR PARMELE CARDWELLNewark
HOMER ISAAC SILVERSVentnor
JACOB ALLEN YAGERPaterson
ELIAS JOSEPH MARSH, *Consultant*Paterson

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Publication

HENRY C. BARKHORN, *Chairman*Newark
EDWARD JOSEPH ILLNewark
JAMES LAWRENCE EVANSNorth Bergen
WILLIAM JOHN CARRINGTON, *Ex-Officio*Atlantic City
ALFRED STAHL, *Ex-Officio*Newark
FRANK OVERTON, *Editor*Trenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Newark.....July 27, 1938.....4:30 p. m.
Newark.....Aug. 31, 1938.....4:30 p. m.
Newark.....Sept. 28, 1938.....4:30 p. m.
Newark.....Oct. 26, 1938.....4:30 p. m.
Newark.....Nov. 23, 1938.....4:30 p. m.
Newark.....Dec. 28, 1938.....4:30 p. m.
Newark.....Jan. 25, 1939.....4:30 p. m.
Newark.....Feb. 22, 1939.....4:30 p. m.
Newark.....Mar. 29, 1939.....4:30 p. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Exhibits

ASHER YAGUDA, *Chairman*Newark
JAMES GORDON BOYES, *Vice-Chairman*Plainfield
NICHOLAS MARK ALTERJersey City
WILLIAM WOLF HERSOHNAtlantic City
LUTHER AGUSTUS MARKLEYTeaneck
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Program

CLARENCE LADELLE ANDREWS, *Chairman*Atlantic City
ROBERT SPEER GAMON, *Vice-Chairman*Camden
LOUIS CHARLES LANGEWeehawken
HARRISON STANFORD MARTLANDNewark
PAUL BRYSON REISINGERTrenton
WILLIAM JOHN CARRINGTON, *Consultant*Atlantic City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Study of Sterilization

CHARLES WRIGHT MACMILLAN, *Chairman*Passaic
SAMUEL EMLEN STOKES, *Vice-Chairman*Moorestown
WALTER JOHN FARRTeaneck
THEODORE RUSSELL ROBIEEast Orange
ALFRED FREDERICK SPERRABound Brook
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Traffic Accidents

ELBERT STETSON SHERMAN, *Chairman* Newark
MILLARD FREEMAN SEWALL, *Vice-Chairman* Bridgeton
THOMAS SIMON PADDOCK FITCH Plainfield
CHRISTIAN PETER SEGARD Leonia
GEORGE JOHN YOUNG Morristown
JESSE LYNN MAHAFFEY Haddonfield
WATSON BUDLONG MORRIS, *Consultant* Springfield
ARNOLD VEY, *Technical Adviser*, representing A. W. Magee, Commissioner of Motor Vehicles of N. J. Trenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Tuberculosis

ABRAHAM EZRA JAFFIN, *Chairman* Jersey City
SAMUEL BUDD ENGLISH, *Vice-Chairman* Glen Gardner
NORMAN WYSELL BURRITT Summit
LEO BERTHIER DRAKE Franklin
CLYDE M. FISH Pleasantville
MARCUS WARD NEWCOMB Browns Mills
HAROLD SIMON HATCH Morristown
JOHN EDMUNDS RUNNELLS Scotch Plains
HARRY BURTON WALKER Vineland
FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Venereal Disease Control

CHARLES BYRON BLAISDELL, *Chairman* Long Branch
MARSHALL DAVIS HOGAN Boonton
BAXTER ALFONSO LIVNGOOD Swedesboro
STANLEY MARTIN MCGEEHAN Atlantic City
ROBERT RAYMOND SELLERS Newark
STANLEY R. WOODRUFF Jersey City
WILLIAM FRANCIS COSTELLO, *Consultant* Dover
ARTHUR JAY CASSELMAN, *Technical Adviser*, representing Dr. Jesse Lynn Mahaffey, Director of N. J. Dept. of Health Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Voluntary Health Insurance

EDWARD W. SPRAGUE, *Chairman* Newark
GEORGE B. GERMAN Camden
ELTON WALLACE LANCE Rahway
WILLIAM C. RUCKER Hackensack
FRANCIS HARRISON TODD Paterson

Welfare

HILTON SHREVE READ, *Chairman* Ventnor
WILLIAM JOHN CARRINGTON, *Ex-Officio* Atlantic City
ALFRED STAHL, *Ex-Officio* Newark
DAVID BACHARACH ALLMAN Atlantic City
FRANK WILLIAM ASH Paterson
GEORGE BARTON BARLOW Englewood
FRANK A. BIEN Irvington
ARTHUR WALTER BINGHAM East Orange
CHARLES BYRON BLAISDELL Long Branch
WENDALL JONES BURKETT Pitman
NORMAN WYSELL BURRITT Summit
EDGAR PARMELE CARDWELL Newark
HARRY NOAH COMANDO Newark
MARCUS ALBERT CURRY Greystone Park
WALTER JOHN FARR Teaneck
FRANK L. FIELD Far Hills
GEORGE WASHINGTON FITHIAN Perth Amboy
JACOB IRVING FORT Newark
BARCLAY STOKES FUHRMANN Flemington
GEORGE B. GERMAN Camden
JOSEPH BERKELEY GORDON Marlboro
DAVID WRIGHT GREEN Salem
DANIEL LEO HAGGERTY Trenton

DONALD OSBORN HAMBLIN Bound Brook
HENRY HAYWOOD New Brunswick
EUGENE GARFIELD HERBENER Lakewood
WILLIAM GETTIER HERRMAN Asbury Park
ERNEST GARFIELD HUMMEL Camden
ALLEN GILBERT IRELAND Trenton
ABRAHAM EZRA JAFFIN Jersey City
SIGURD WALTER JOHNSON Passaic
ROBERT ANTHONY KILDUFFE Atlantic City
JOSEPH HENRY KLER New Brunswick
ISAAC WARNER KNIGHT Pitman
FREDERIC WILLIAM LATHROP Plainfield
JULIUS LEVY Newark
CHARLES LITWIN Teaneck
JOSEPH FRANCIS LONDRIGAN Hoboken
CHARLES WRIGHT MACMILLAN Passaic
JACOB JOHN MANN Perth Amboy
WILLIAM WALLACE MAVER Jersey City
CHARLES HENRY MITCHELL Trenton
BARCLAY WELLINGTON MOFFAT Red Bank
HERSCHEL STRATTON MURPHY Roselle
LESLIE EDWIN MYATT Bridgeton
STANLEY HETFIELD NICHOLS Long Branch
JAMES FRANCIS NORTON Jersey City
BERTHOLD STEINBACH POLLAK Secaucus
WARREN DAVID ROBBINS Cape May
MILLARD FREEMAN SEWALL Bridgeton
TRAUGOTT JOHN SCHUCK Hoboken
REUBEN LORE SHARP Camden
BYRON GRANT SHERMAN Morristown
HOMER ISAAC SILVERS Ventnor
SPENCER TREADWELL SNEDECOR Hackensack
JAMES HERBERT SPENCER, JR. Franklin
SAMUEL EMLEN STOKES Moorestown
*THEODOR TEIMER Newark
ADOLPH TOWBIN Lakewood
CHESTER ISAAC ULMER Gibbstown
HERBERT ROY VAN NESS Newark
WILLIAM HENRY VARNNEY Washington
HARRY BURTON WALKER Vineland
WILLIAM CRANE WILENTZ Perth Amboy
JACOB ALLEN YAGER Paterson
GEORGE JOHN YOUNG Morristown
ANTHONY CHARLES ZEHNDER Newark

Meetings

Trenton.....June 5, 1938.....1 p. m.
Trenton.....Oct. 2, 1938.....1 p. m.
Trenton.....Dec. 4, 1938.....1 p. m.
Trenton.....Feb. 19, 1939.....1 p. m.
Trenton.....Apr. 16, 1939.....1 p. m.

Woman's Auxiliary

GUSTAV AUGUST BRAUN, *Chairman* Newark
WILLIAM KING CAMPBELL, *Vice-Chairman* Long Branch
LOUIS FEINSTEIN Atlantic City
GERALD ELLSWORTH McDONNELL Mt. Holly
JOSEPH ROWLETT MORROW Ridgewood
ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Workmen's Compensation

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ROY GRIFFITH, *Technical Adviser*, representing the Manufacturers' Association of N. J. Glen Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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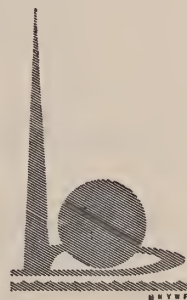
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● The past twenty years of biochemical research have steadily brought additions to the list of vitamin factors known to be indispensable in proper human nutrition. Today, only vitamins A, B₁, C and D, riboflavin and the P-P factor are universally considered as essential to man. In general, the requirement for these factors is greater in certain phases of the human life cycle than in others.

This list of essential factors is probably incomplete. It has been aptly stated (1) that our species has evolved in the direction of lengthening rather than shortening the list of known dietary essentials. However, it is reasonable to believe that the above list, although incomplete, probably does include all factors whose absence from the ration may cause the most severe types of human dietary deficiency disease.

Investigations on the nutritive requirements and the biochemistry of the lower forms of animal and plant life constitute the frontiers of modern vitamin research. From studies such as these may come the first clues as to new vitamins which may ultimately be proven essential in human nutrition. For example, it was upon research of this type that the dietary requirement of the rat for riboflavin was established and

the importance of riboflavin (1) in human nutrition postulated.

During recent years, a large number of factors essential to animals other than man has been enunciated (2). As examples might be mentioned the factor in plant juices required by herbivora (3); the factor in fresh meat essential to trout (4); and vitamin K, needed for normal blood coagulation in fowls (5). Whether these or others of the factors essential to lower forms of life will also prove indispensable to man, the future must decide.

The knowledge that our present list of essential vitamins may be incomplete, need not be alarming. However, such knowledge should serve to emphasize the desirability of a diet formulated according to the best present concepts of the science of nutrition. Nature intends that man should receive all dietary essentials, known or unknown, through food and it will be through the medium of a judiciously chosen, varied diet that these essentials can best be obtained. Needless to state, the several hundred varieties of wholesome, nutritious, commercially canned foods lend themselves admirably to formulation of such varied, protective diets.

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(1) 1938. J. Amer. Med. Assn. 110, 1278.

(2) 1938. Ibid. 110, 1441.

(3) 1936. Proc. Soc. Exper. Biol. Med. 35, 217.

(4) 1928. Science. 67, 249.

(5)a. 1935. Nature. 135, 652.

b. 1935. Biochem. J. 29, 1273.

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... for the patient with early syphilis

... for the patient who is sensitive to arsenic



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¹J. A. M. A. 111:2175 (Dec. 10), 1938.

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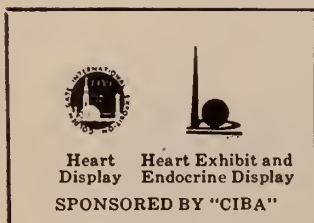
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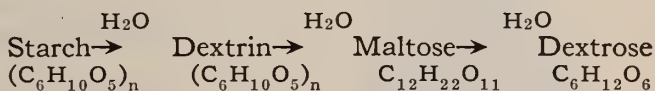
2. Q. What are the Karo equivalents?

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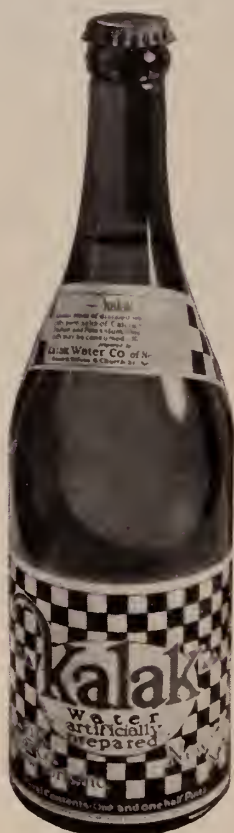
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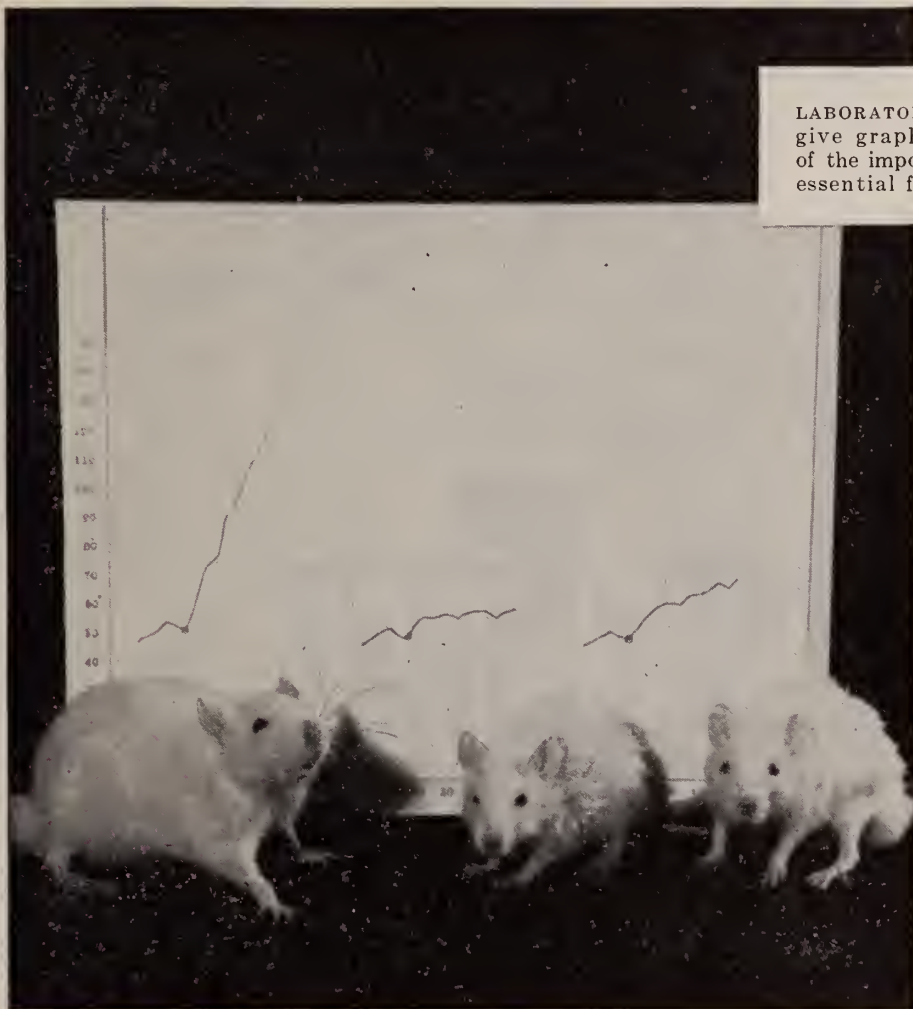


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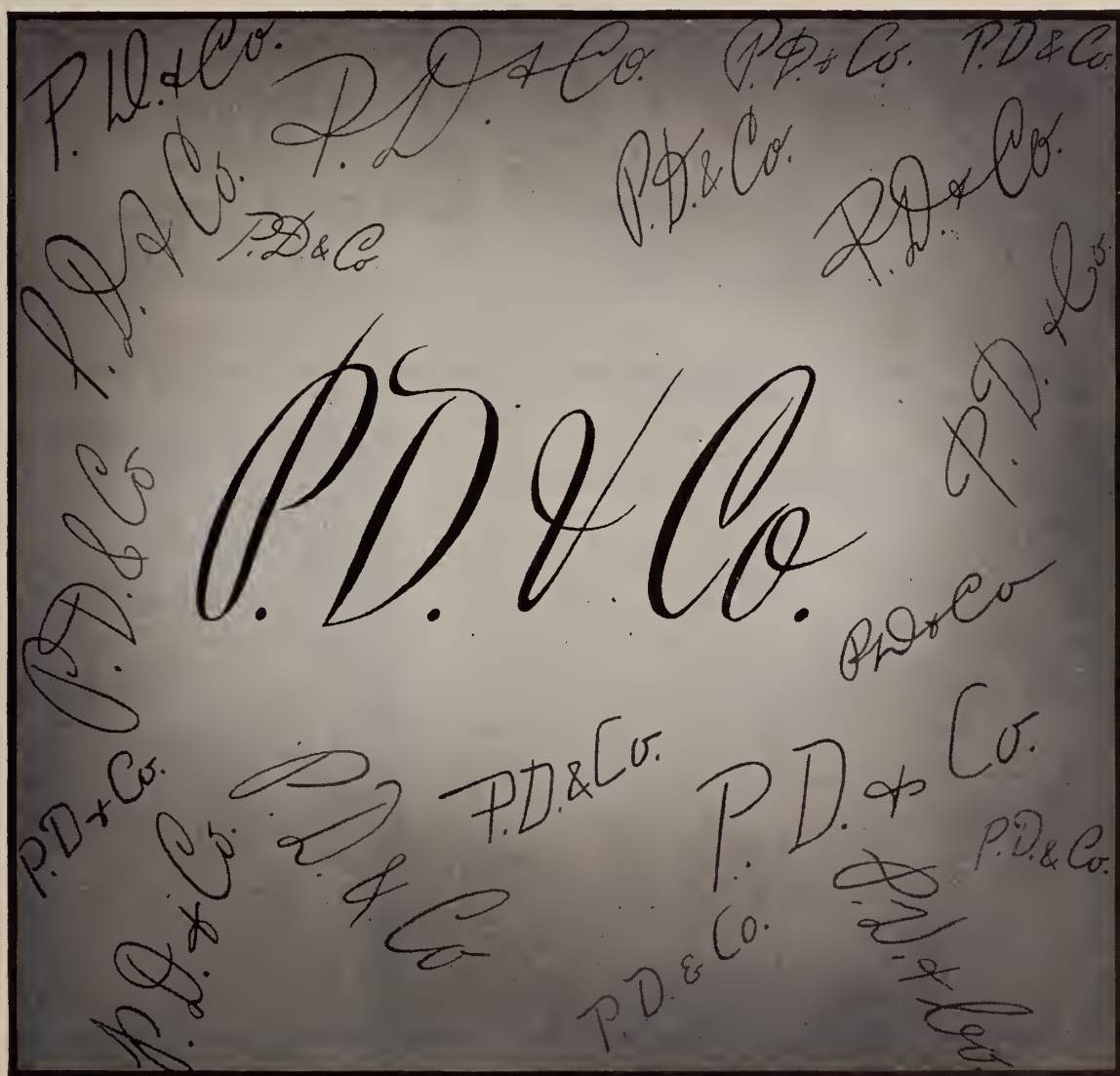
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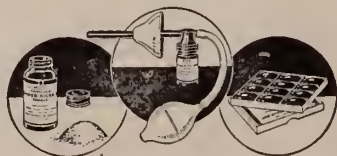
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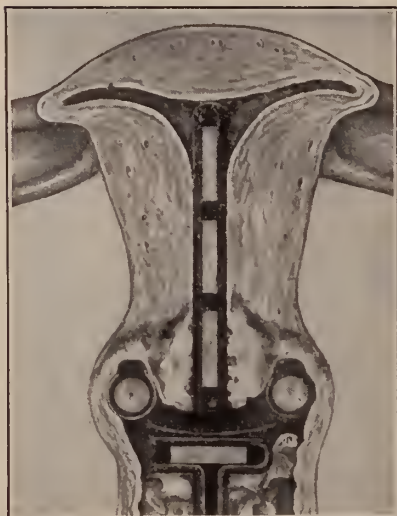
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NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	New Brunswick 49
NEWARK	Arnold's Pharmacy, Mt. Prospect Ave. at Heller Pkwy.	HUMBoldt 3-4134
PATERSON	Charles F. Prescription Pharmacy, Main & Market Sts.	SHERwood 2-6153
MORRISTOWN	Davis Brothers, 2 South St.	MORRistown 4-0002
EAST ORANGE	Bell Drug Co., 382 Main St.	ORange 3-7051
BERNARDSVILLE	Hemmendinger Pharmacy, 12 Mine Brook Rd.	BERnardsville 78
NUTLEY	Clyde W. Heberling, Passaic & Nutley Aves.	NUTley 2-2350-51
NEWARK	Eckert's Prescription Pharmacy, 167 Ferry St.	MARKet 2-8998
WEST NEW YORK	The Owl Pharmacy, 783 Bergenline Ave.	UNION 7-9043
HACKENSACK	Gorman-Noble Drug Co., 269 Main St.	HACKensack 2-0660
EAST ORANGE	Kaye's Drug Store, 392 William St.	ORange 5-7870
NEW BRUNSWICK	A. W. Reeve, 229 George St.	New Brunswick 582
ENGLEWOOD	Buckley's Drug Store, 35 E. Palisade Ave.	ENGlewood 3-5354
RED BANK	The H. T. Young Pharmacy, 85 Broad St.	Red Bank 164
ASBURY PARK	Hill's Asb'ry Pk. Drug Store, Mattison Ave. & Bond St.	Asbury Park 50
LONG BRANCH	Dangler's Pharmacy, Eatontown—Eatontown 510	Long Branch 351
BELMAR	William T. Lins, 1500 F St., cor. 15th Ave.	Belmar 559
POINT PLEASANT	Point Pleasant Pharmacy, 611 Arnold Ave.	Point Pleasant 112
ELIZABETH	Graham & McCleskey Co., 57 Broad St.	ELIZabeth 2-0400
JERSEY CITY	Smith & Williams, 343 Jackson Ave.	BERgen 3-2616
BAYONNE	Nelson Dittmar, Ph. G., 924 Broadway at 44th St.	BAYonne 3-0406
PALISADES PARK	Morsemere Pharmacy, Inc., Columbia & Broad Aves.	MORs'm're 6-5108, 5497
CLIFFSIDE	Louis C. Ghiosay, 639 Anderson Ave.	CLIFFside 6-3834
MAPLEWOOD	Charles Matter, Ph. G., 1755 Springfield Ave.	South Orange 2-4471
HILLSDALE	Nielsen Pharmacy, 100 Broadway	Westwood 159
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EDITORIALS

Evaluating the Survey of Medical Services

It is frequently said that everybody knows about the services which the medical profession renders to the people. The truth is that what everybody knows, no one knows with any degree of accuracy. This is true regarding the quantity and value of the services rendered by the family doctor, particularly those which he donates.

The Federal Government has publicized the assertion that one-third of the people of the United States are not receiving efficient medical service. It has based this charge on a superficial survey made by W. P. A. investigators who visited each home in certain districts, including Trenton. While the survey was in progress, the Executive Offices of the State Society received a letter stating that the detailed record of the Trenton survey would be sent to it so that the findings could be verified. Two later inquiries elicited the same reply, but no report was received and no verifications of the W. P. A. worker was possible. The Medical Society of New Jersey therefore undertook to make its own survey of sickness based on forms supplied by the American Medical Association.

The replies received from hospitals, welfare departments and organizations, and other groups engaged in public health services, were comprehensive and accurate because these organizations had always maintained staffs which kept accurate records of the findings of the field workers. On the other hand, physicians in private practice, unaccustomed to any form of publicity regarding their relations to their private patients, were often confused over the classifications on the report blanks.

It will take some time to collate the reports of the survey, but two tangible results are evident:

1. The reports will reveal the health services rendered by each organized group of health and welfare agencies.
2. It has given family doctors experience in making out reports along practical lines in which they have never before been consulted.

The Federal Survey was made in a few selected regions; but The Medical Society of New Jersey undertook to make a survey of the entire State, using blank forms that were supplied by the American Medical Association.

Histories of the State and County Medical Societies

The practice of medicine in New Jersey has had a slow development over three periods of time.

1. THE COLONIAL PERIOD

The first period was that of uncontrolled practice by individuals, extending from early colonial times up to the year 1766. During these years the centers of population were too small to support full-time doctors, and too far apart to permit them to meet together regularly and develop a coöperative plan of action.

2. THE MEDICAL SOCIETY OF NEW JERSEY

The second period was the half century of organized efforts to establish state-wide standards of medical education and practice under the leadership of The Medical Society of New Jersey, beginning with its founding on July 23, 1766.

3. COUNTY MEDICAL SOCIETIES

The third period began with the establishment of county medical societies under charters from The Medical Society of New Jersey, in accordance with the State Law of 1816. This period has continued for 122 years, up to the present time.

COMMUNITY PARTICIPATION

The medical profession of New Jersey is now well advanced in a fourth period of practice,—that of *community participation in the distribution of medical services*. One of the greatest fields of action of the official medical societies today is that of *diagnosing* the medical needs of the *community*; and that of *prescribing* the means of their *treatment*. The relation of the Medical Society to the community is now like that of the qualified physician of 1816 to his individual patient. The competitors of the qualified physicians during the first half century of The Medical Society of New Jersey were the uneducated practitioners, who outnumbered those who were scientifically trained. The modern competitors of the medical societies are social organizations and governmental boards whose members lack the knowledge and experience which only the leaders of medical societies can supply. The

early history of The Medical Society of New Jersey supplies abundant precedents for the civic methods which must still be followed in the preservation and further development of the efficient distribution of the services of scientific medicine.

PLAN OF THE MEDICAL HISTORY OF NEW JERSEY

The history of organized medicine in New Jersey begins with that of The Medical Society of New Jersey, which was founded on July 23, 1766, by seventeen physicians, two of whom were also pastors of churches. During the first thirty years of its existence, seventy-four new members were added to its rolls; and fifty-five were added during the next twenty years. A total of 146 members was therefore enrolled during its first half century of life. The average attendance of the members at the meetings was less than that of the smallest county society today; but the members were leaders in civic affairs as well as medical. The basic principles of their civic participation in the distribution of medical services have endured; and are still the bases of the civic activities of medical societies.

The Medical Society of New Jersey has adopted the project of compiling a history of the medical societies of the State and the counties, based on their official records. The history of the State Society will be written first, because it existed for fifty years before it gave birth to the county societies, which adopted and developed the methods of the parent organization. It will be written in a concise form, but the sources of information will be recorded in the text so that the items will be available to future historians in compiling more detailed histories, and also to the county historians in writing their histories.

It is expected that the manuscript of the history of the first half-century of the State Society will be ready for exhibition at the annual meeting.

RECENT HISTORICAL ARTICLES

The scope of the historical articles which have been printed in The Journal in recent years is indicated in the following index:

1. The list of Fellows that is printed in the Official List of Members of the year 1938 includes an outline of the life of each President.
2. May, 1936, pp. 300-307. The First Decade, 1766-1776.
3. September, 1936, pp. 542-546. Meeting Places.
4. November, 1936, pp. 647-649. First Minute Book.
5. October, 1937, p. 634. Public Health Committee.
6. November, 1937, pp. 687-689. Welfare Committee.
7. January, 1938, p. 42. Origin and Development of Board of Trustees.
8. April, 1938, p. 232. List of Secretaries.
9. May, 1938, p. 326. List of Treasurers.
10. County Medical Societies,—organization and charters, Journal, Dec., 1938, p. 747.
11. Charter of Somerset County Medical Society, Journal, Jan., 1939, p. 46.

HISTORIES OF COUNTY SOCIETIES

At its organization meeting in 1766, The Medical Society of New Jersey proposed to meet semi-annually and to establish district or "Inferior" societies, which were to be located in Elizabeth, Bound Brook, Princeton, and Morristown, and were to hold meetings semi-annually midway between those of the State Society. But difficulties of travel were almost insuperable, and the district societies met only occasionally. However, fifty years later, five local societies were formed in the Counties of Middlesex, Somerset, Monmouth, Essex, and Morris, under charters issued by the State Society under the State Law of 1816.

Two years later the State Legislature passed a new act of incorporation by which the State Society should be constituted by four delegates from each of the county societies to whom it granted charters. Since this time the county societies have functioned both as independent units in their own territories, and also collectively by means of their representatives in the State Society. A history of each county society is therefore as important as that of the parent State Society.

SOURCES OF INFORMATION

The principal sources of information regarding the history of a county society are as follows:

1. The minute books: Where are they? What periods do they cover?
2. The charter issued by The Medical Society of New Jersey: Is one in existence?
3. The biographies of the founders and leaders, and the civic positions which they held.

4. Records of examining and licensing candidates to practice. Examples of licenses.

5. Biographies and records secured by the Woman's Auxiliary. Excellent collections of over 200 biographies,—many with photographs,—have been collected by the Auxiliaries of the Counties of Atlantic, Burlington, Camden, and Mercer.

6. The historical societies of the several counties, particularly Cape May, Gloucester, and Camden.

The following histories of county societies have appeared in the Transactions of the State Society:

1. Essex, 1866, pp. 184-187, and 1867, pp. 77-181.
2. Monmouth, 1871, pp. 69-104.
3. Cumberland, 1871, pp. 105-188.
4. Hunterdon, 1872, pp. 91-213.
5. Warren, 1890, pp. 187-288.
6. Passaic, 1894, pp. 133-215.
7. Camden, 1896, pp. 273-313. This is an abstract of Dr. Godfrey's history of 300 pages which includes frequent references to projects of the State Society.
8. Gloucester, 1899, pp. 358-369.
9. Atlantic, Journal, July, 1930, pp. 636-646.

PUBLIC RELATIONS

It is extremely desirable that the relations of the county society to other health agencies be recorded, particularly the following:

Hospitals.
Nursing Services.
Health Departments and local Health Officers.
Tuberculosis.
Sanitation—sewage disposal, milk, etc.
Welfare Organizations—"Poor houses".
Public Schools.

HISTORICAL COMMITTEE

In order to carry out the project of Medical History it will be necessary that each county society appoint a committee to have charge of the project.

EXHIBIT AT THE ANNUAL MEETING

It is planned that an exhibit of *historical* material shall be arranged at the annual meeting by the Woman's Auxiliary. The photographs on page 188 of this Journal demonstrate the essential value of last year's exhibit. An abundance of space will be provided this year in an accessible location.

Each county society is urged to send material for the exhibit,—for example, the original book of minutes.

Psychic Bases for Physical Disorders

"Forty per cent of all problems for which the advice of physicians is sought arise from somatic manifestations of emotional disturbances having their origin both within and external to the individuals; and unless the practicing physician understands those manifestations, he cannot deal with them effectively."

This principle was stated by Dr. Stephen P. Jewett, Chief of the Psychiatric Division of the Metropolitan Hospital, New York City, in an address before the Passaic County Medical Society at its monthly meeting on February ninth (see page 184). This is only one-half of the principle,—that of *diagnosis*.

Dr. Jewett also explained the other half of the principle—that the first essential in *treatment* is that the doctor shall listen attentively and sympathetically to the patient's own story of his ailment, and shall prescribe for what the patient thinks is the matter with himself; as well as for the pathological condition or manifestation which is diagnosed by the doctor.

The faith which a patient has in his physician is an essential element in the success of the doctor's treatment. The doctor who is long in his knowledge of human nature is usually prosperous even though he is often short in scientific knowledge and ability. Every patient presents a mental problem, as well as a physical defect; and its treatment consists in implanting a feeling of hope where fear and despondency have been dominant. To tell a patient that his feelings are imaginary only drives him to a less skillful doctor. A placebo for the *mental* state is as important as a scientific prescription for the *physical* state of the patient.

STATE MEDICINE

The same principle of the Doctor-Patient relation in private practice applies equally well to "State Medicine", and "Compulsory Health Insurance".

The *medical society*—that of the county, state, and nation—is the medical adviser of the welfare leaders of the county, the state, and the nation, who presume to prescribe popular placebos as curative measures, when strong medicine and possibly a major operation is indicated.

There is a science of *administrative* medicine as well as that of private practice. The leaders of the great welfare agencies and political organizations are now making their own diagnoses of community conditions, and are demanding placebos of their own prescribing. They are now in the position of a "Nervous patient", and the problem of each medical society is to retain the confidence of the people in its own sphere of action, while at the same time it prescribes a scientific system of community therapeutics which the people—the taxpayers—will take and like.

THE SCHOOL OF THE MEDICAL SOCIETY

During the past two decades the great welfare and political organizations have conducted a nation-wide school—or rather propaganda—consisting of popular lectures, radio talks, and welfare demonstrations, setting forth their own conceptions of administrative medicine. Practicing physicians are now beginning to realize that they too must institute a broad system of instruction in administrative medicine. The medical schools have neglected to give courses in this subject; and therefore the duty of instructing practitioners of medicine along administrative lines devolves upon the medical societies, beginning with those of the counties, and extending to the State Societies and to the National Society—the American Medical Association.

The Medical Society is no longer a loose confederation of individual doctors, each practicing his own private system. Every county and every section of the county has its own problems in administrative medicine which its local physicians can solve by united study and agreements. If, for example, a welfare organization proposes to establish a clinic, the local physicians, through their county medical society, can direct its operation along the lines of sound medical science and practice. Every county society must therefore be a school of research into local needs, and also into standard methods of meeting those needs. The day of blind opposition has passed and that of co-operation has arrived.

This same principle applies also to the State Society and the A. M. A.

THE PROFESSION OF NEW JERSEY

Governor Moore has requested The Medical Society of New Jersey to advise him regarding the unfilled medical needs of the State and to suggest practical methods of meeting those needs. The methods of coöperation of the medical profession with the State Department of Health and the Department of Institutions and Agencies are well known to experienced observers throughout the nation, and are quoted and commended more widely than individual physicians may realize.

The county society is the fundamental school

in which physicians learn the principles of administrative medicine as effectively as they learn scientific medicine in the medical schools. From its elementary instruction they advance into the broader courses offered by the State Society and the American Medical Association.

Each local community looks to its county medical society for advice regarding all phases of administrative medicine, just as the individual patient confides in his family doctor. The ills of the community, like those of the individual patient, have a psychiatric element whose diplomatic consideration will lead to the people's confidence in the purely scientific forms of treatment offered by the medical profession.

Controlling One's Destiny

There are times in every doctor's career when he encounters a run of success. Day after day passes when all goes well with his patients, and he falls an easy prey to their praise and thanks. His step lightens, his chin goes up, and he pats himself on the back and says, "What a big boy am I!" He is satisfied and pleased with himself and his work.

Then all unexpectedly comes the period when day after day adversity dogs his footsteps. As one day follows another, and adversity clings on, his chin gradually falls, his face lengthens, his step becomes heavy, and the sunshine of his countenance gleams less brightly; and as despair deepens, he reproaches himself with "What a big chump am I!"

An elderly, sympathetic doctor once expressed his philosophy something like this:

"Beware of the days when all goes well; beware of the word of praise and the pat on the back, for all such things are fickle. But when Old Man Adversity knocks at your door,

do not try to holler loud enough to drown the sound of his knocking. Ask the old croaker to come in and justify his visit. Be candid with him, strip him of his cloak of mystery and find the purpose of his visit. From him you may learn much; but he is a peculiar sort of fellow in that, the more you learn from him, the less often does he knock at your door, and the happier are your days."

And so it is that the doctor is more likely to evaluate himself when his emotional reactions are at a subnormal ebb. Have we not seen this many times among professional friends whom we held in high regard?

Why doesn't he take that vacation he had planned; and after accustoming himself to a life of leisure, take stock of himself when his emotions are at an even, quiet ebb? Then knowing himself, he will realize what sort of person his associates think he is,—a conscientious worker, an understanding friend, a tolerant gentleman, a sympathetic doctor—his true self.

Annual Reports of County Societies

The policy of a "Continuing Program" of The Medical Society of New Jersey has proven itself to be valuable in organizing our efforts in the pursuit of certain definite objectives. To carry on this policy, the reports of the Officers and Committees of the Society are necessary, so that a yearly summary of the activities can be formulated and the advances made can be measured. The procedures furnish a basis for outlining the program for the next administra-

tion and the immediate objectives can be considered and decided upon. Plans and schedules are then made and the organized effort of the members can be guided.

The time is now ripe for each component County Medical Society to summarize its efforts and achievements in a yearly report by the President, so that we may all know that we are in accord as to our objectives.

LEROY A. WILKES.

"A Premature Health Program"

An editorial in the New York Herald-Tribune of March 2, 1939, is an excellent summary of the attitude of the members of The Medical Society of New Jersey toward the Wagner Bill's appropriation of \$80,000,000 for new hospitalization, instead of the \$850,000,000 asked by the Federal Administration. The editorial says:

But still it asks too much. Happily the health of its inhabitants is not declining. On the contrary, according to the Interdepartmental Committee, the general health in the United States was never higher. Incidentally, we can think of nothing better calculated to boost the general level of health than a durable recovery with its cure of the worries caused by insolvency and unemployment. Surely this, and not provision of medical care, should for the time, absorb the attention of the government.

There is another compelling reason for concluding that Senator Wagner's program is premature. We have not yet digested the social security serv-

ices already in operation. * * * We have for it the word of experts, including that of the American Association for Social Security which only recently demanded that we bring order out of the chaos of our present local security efforts, before expanding them. Yet one finds Senator Wagner introducing his bill for health protection with the remark that "We must take action now to conquer this last remaining frontier of social security in America." While over-extension threatens the collapse of the whole experiment, he blithely presses on, or is pressed on by the Administration. Such policy is the hall-mark of the New Deal statesmanship.

It is the policy of The Medical Society of New Jersey, and of the societies of the several counties, to diagnose the deficiencies in the distribution of medical services in each community, and to correct them by a friendly co-operation between the practicing physicians and the local welfare agencies.

The Survey of Personal Service

The family doctor is the center around whom all medical service revolves. He deals with individuals who avoid publicity even as he himself does. Yet an estimate of the number of his calls is necessary in order to demonstrate the great extent and efficiency of the services which he renders to the community.

Cold statistics are what count in these days of organized effort. They are the only efficient answer to the charges of welfare organizations and welfare agencies that the family doctor is failing to give the amount of medical service that the people need.

The present state-wide survey of private medical practice is the first that has ever been attempted by the doctors themselves; and the family doctor is to be excused for his uncertainty over forms which he has been asked to fill out with no previous experience or even instruction. Under these conditions the response of the family doctors may rightly be termed "Gratifying".

The survey will have the desirable effect of causing the family doctor to view his own work from the standpoint of an impartial observer.

ORIGINAL ARTICLES

FETAL MORBIDITY AND MORTALITY IN LATE TOXEMIA OF PREGNANCY

By VINCENT DEL DUCA, M.D., Camden, N. J.

Read before the Section on Pediatrics of the Annual Meeting of The Medical Society of New Jersey,
May 18, 1938.

Although much has been written recently about late toxemia of pregnancy concerning its possible causes and the clinical picture in the mother, there is relatively little regarding the fate of the offspring. As we consider this side, many questions naturally arise. For example:

1. How much does the maternal toxemia damage the fetus?
2. Does it interfere with growth or development?
3. Does it produce any characteristic pathological changes in the fetus?
4. Is breast feeding advisable in eclampsia?

Some of the more noteworthy contributions on the subject might be briefly stated.

B. Tunis reports that of 1629 births of eclamptic mothers, there were 654 deaths, or 40 per cent mortality. He suggests that the high mortality depends not on the transmission of any toxic factor from the mother to the fetus, but on the high prematurity rate in late toxemia.

Abt presents statistics from the Chicago Lying-In Hospital on 224 babies born of mothers suffering from late toxemia of pregnancy. Of these, 39, or 17.4 per cent, were born dead; and 16, or 7.1 per cent, died in the hospital,—a total mortality of 24.5 per cent.

Cruick-Shank states that of the offspring of 814 eclamptic mothers, 28.8 per cent were mature living children; 10.6 per cent premature but alive; 30.9 per cent stillborn.

Only a few authors have studied the histological changes in the fetus of mothers with late toxemia. Schmorl reported hemorrhages in the liver in two cases, and areas of degeneration in the kidney in four cases. All were stillbirths of eclamptic mothers. Lubarsch noted

epithelial necroses and hemorrhages in the kidneys and hyaline thrombi in the vessels. Dienst observed hemorrhage and anemia necrosis in the liver and kidneys of a full-term infant born of an eclamptic mother.

Material and the records taken from the Red and Blue services of the Pennsylvania Lying-In Hospital showing the statistical observations of the offspring of eclamptic and preëclamptic mothers disclose the following facts: Out of 50 cases of eclampsia and 110 cases of pre-eclampsia, there were two sets of twins in the eclamptic group, and three in the preëclamptic group, the remainder being single births. In this group 94 cases were primiparas and 66 were multiparas.

Since the condition at birth may be considered a fair criterion of the vitality of the baby, we noted the following:

- 80 babies were in good condition
- 20 babies were in fairly good condition
- 18 babies were considered in a weak condition
- 20 babies were asphyxiated
- 27 babies were born dead

Among the causes of death, one appeared to be the direct result of the maternal toxemia. This was a stillborn child of an eclamptic mother showing acute degeneration of the liver.

In three other cases the autopsy findings were unusual. The first case was that of an infant weighing five pounds one ounce, born of an eclamptic mother, whose brain showed marked gliosis of the cortical cells that could not be explained on any other basis than the toxemia.

The second infant weighed four pounds nine ounces. The mother had eclampsia. Labor

lasted twelve hours and delivery was spontaneous. The infant was very weak, and died in thirty hours. The autopsy revealed interesting brain changes. The microscopic sections showed bacterial invasion of the meninges, and a definite cellular reaction. The endothelium of the capillaries of the cortex were swollen, and sometimes filled the lumen of the vessel.

The third case was that of a child weighing six pounds eleven ounces, born of a mother with moderate toxemia. The cortical endothelium was swollen, sometimes to such a degree as to produce occlusion of the lumen. There was no proliferation of the endothelium. The space around the capillaries was swollen and edematous, but there were no signs of cellular reaction, owing probably to the fact that the course was so rapid. The cortical ganglion cells and the interstitial tissue were all edematous. The outstanding features were the endarteritis and the accompanying edema.

In addition to the born dead, we had thirteen infants die in the hospital, a total mortality of 24.2 per cent.

A consideration of the birthweights is very interesting. In the eclamptic group, the average weight was five pounds six ounces (2430 gms.), 28 per cent of whom fell in the arbitrary group, based on birthweights the upper limit of which is four pounds six ounces, and is said to include babies prematurely born and not likely to live.

These figures point to the fact that there are more premature infants born of eclamptic mothers than the average. This is probably due to the fact that the severe toxic state of the mother causes the premature termination of pregnancy.

The average birthweight of the preëclamptic group was six pounds six ounces,—considerably above that of the eclamptic group and more nearly approaching the normal birthweight. Thirteen per cent of these came under the classification "premature and not likely to live".

It was interesting to note that 52 per cent of all the babies regained their birthweight by the eleventh day. The febrile reactions differed in no great degree from other babies of similar weight. Other diseases of the new-born did

not occur with any significant frequency. There were three cases of convulsions in the eclamptic group, and two in the preëclamptic. These convulsions were due to causes other than the toxemia. There were three cases of severe icterus in the eclamptic group and one in the preëclamptic group. Hemorrhagic disease of the new-born occurred in three cases with one fatality.

The majority of the cases were followed in the Well-Baby Clinic for a time varying from one month to one year. From observation and a thorough study of the data, we were unable to show any effect directly attributable to the maternal toxemia.

The story of one child illustrates how little these children may be affected: This was a premature baby weighing two pounds one ounce, born of a primipara thirty-four years of age, who complained of dizziness and swelling of lower extremities. Her blood pressure was 154 systolic, and 102 diastolic. The child was cyanotic at birth and required inhalational therapy for a few days. He regained his birth weight by the eleventh day, and was discharged from the hospital on his seventy-sixth day weighing five pounds twelve ounces, and in a very good condition.

The question of breast feeding in eclampsia is worthy of comment. Holt and Howland state that the nursing of these babies, even two or three days after the convulsions, is dangerous. Dennett considers puerperal convulsions as a contraindication to breast feeding. Frost and Goodall believe the milk of eclamptic mothers to be toxic and advise against nursing. Reuss, on the other hand, believes there is no harm in breast feedings under such circumstances.

It has been our practice to have eclamptic mothers nurse their babies whenever possible. We were successful in thirty-five of the fifty cases. Every effort was made to encourage breast feeding. The procedure in these cases was as follows: The babies were not put to breast the first few days, but breast stimulation was accomplished by breast pumpings as soon as the obstetricians permitted. The milk thus obtained was discarded. When the mother showed marked improvement, the baby was

placed upon the breast under careful supervision. In no instance did we note any toxic effect from the mother's milk. Many of the failures in breast feeding were due to unfavorable influence on milk production as a result of the treatment necessary in these cases, especially when dehydration and increased elimination were used.

SUMMARY

1. One hundred and sixty mothers suffering from eclampsia and preëclampsia were investigated. There were born 165 babies, of whom there were five pairs of twins, and 155 single births. Toxemia occurred more frequently in primiparas than in multiparas.

2. Twenty-seven infants were born dead, and thirteen died while in the hospital,—a total mortality rate of 24.2 per cent.

3. The average birthweight in eclamptic

group was five pounds six ounces; 28 per cent of whom were less than four pounds six ounces.

The average birthweight in the preëclamptic group was six pounds four ounces, 13 per cent of whom were less than four pounds six ounces.

4. Only one infant showed postmortem evidence of change due to maternal toxemia. Three others showed brain changes that may have been due in whole or in part to the maternal toxemia.

5. Maternal toxemia did not seem to effect any permanent damage in infants who survived.

6. It is advisable for eclamptic mothers to nurse their babies when the signs of toxemia have disappeared.

406 Cooper Street, Camden, N. J.

THOUGHTS ON DISEASE OF THE STOMACH AS INTERPRETED BY THE GASTROSCOPE

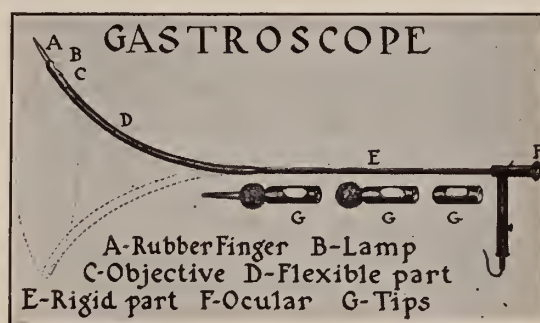
By WILLIAM A. SWALM, M.D., and LESTER M. MORRISON, M.D., Philadelphia, Pa.

From Temple University Medical School, Gastro-Intestinal Department. Read before the Section on Gastro-Enterology of the Annual Meeting of The Medical Society of New Jersey, May 17, 1938.

It is indeed a testimonial to the scientist's ingenuity to note the great advances made in the gastroscope since the time when Kussmaul had a sword-swallower swallow the first gastroscope in 1868. This instrument at that time was really an elongated edition of the present cystoscope, and is certainly a far cry from the present semi-flexible Wolf-Schindler gastroscope.

The ease with which this instrument is passed is enhanced by the new Schindler hypopharyngeal anesthetizing tube. This has made the passage of the tube into the hypopharynx, which was formerly a difficult and often uncomfortable zone, a comparatively easy and simple procedure. However, the comparative ease which the semiflexible Wolf-Schindler gastroscope of 1932 and the hypopharyngeal anesthetizer have facilitated gastroscopy, should not cause us to lose sight of the very definite contraindications to gastroscopy, lest accidents and even fatalities occur.

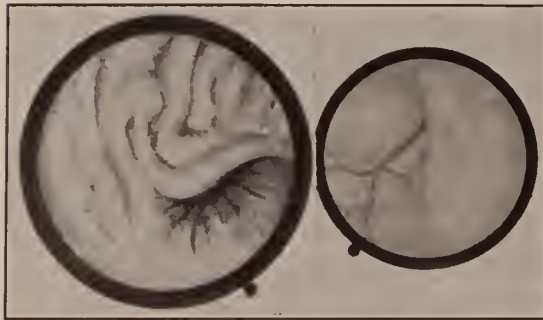
These are most apt to happen in the hands of untrained or unskilled gastroscopists, who



Mechanism of semi-flexible gastroscope
(Wolf-Schindler)

have forgotten such important preparatory work as a preliminary radiologic swallowing function to avoid the possibility of perforating an unsuspected esophageal neoplasm, cardiospasm, esophageal diverticulum, etc. An important point to be remembered is a very

slow and gentle introduction of the instrument, rather than the method of some Europeans of rapid passage. Since the Jackson dictum of "Seeing the lumen ahead of the tube as you go" cannot be followed, great gentleness and carefulness in instrumentation must be substituted. By following this "Golden rule" in collaboration with Dr. C. L. Jackson, we have not had any accidents in over 700 gastroscopies.



Photographs taken from paintings by "Moutier".

Left: Hypertrophic gastritis, with edema and congestion, and tenacious mucus in crypts of hyperplastic rugae.

Right: Atrophic gastritis, with vascular arborizations.

Our routine of preliminary gastro-intestinal x-ray studies during the past few years has revealed, on a number of occasions, some startling data which has proven embarrassing to the radiologist and the gastroscopist alike. For example, that the cardiac end of the stomach is the "graveyard" of the roentgenologist is well demonstrated by routine gastroscopies in patients suffering from gastro-intestinal complaints. Not rarely malignant lesions will be visualized when the gastro-intestinal x-ray series has proven negative. The same conditions pertain to benign lesions. For example, after passing the diaphragmatic pinchcock, we have on several occasions encountered difficulty with the gastroscope, and were at first puzzled by the fact that the x-ray studies reported and apparently revealed "Normal stomachs". However, on attempting to continue gastroscopy, an unyielding obstruction from carcinomatous deformity, or the presence of gross bleeding with infiltrative changes, would be encountered. In some

cases the lesion itself was actually visualized. A re-examination by x-ray was then requested, which confirmed the gastroscopic suspicions. This has occurred frequently enough to drive home the fact that all patients with persisting symptoms after therapy, despite negative and careful x-ray studies, should be gastroscopied. Nor does this have reference only to patients in the cancer age—since we have picked up gastric ulcer of the benign type, which may occur in the younger patient despite negative x-ray studies.

Now we do not wish to decry the x-ray method, nor the radiologist himself, since every technical method is susceptible to error because of the human equation. As a matter of fact, gastroscopists will readily admit the possibility that they too might have erred and missed gastric lesions. This applies to us just as well, since we have recently missed a gastric ulcer on the lesser curvature of the stomach, just distal to the incisura angularis. This was in the gastroscopists "Graveyard" if one might be forgiven for this figure of speech. This source of error lies in the fact that there are three blind spots in the stomach to the gastroscopist. One is just on the lesser curvature in the antrum where the above mentioned ulcer was located; the second in the greater curvature, mid-portion, where the tip of the instrument points on introduction to the second level of depth in the stomach; and the third is located in the pouch-like cardia of the greater curvature of the stomach. Once in a while we cannot quite visualize one spot of the lesser curvature just distal to the diaphragmatic pinchcock.

CHRONIC GASTRITIS

In the past five or six years there has occurred a really surprising change in the attitude of some of our best gastro-enterologists on the gastritis problem. The result has been that observers who were formerly skeptical regarding the very existence of chronic gastritis, not only now speak of chronic gastritis as a definite entity, but actually run gastroscopic clinics in which careful studies on chronic gastritis are being made. Not only have the clinicians made an "about face" regarding the recognition of chronic gastritis,

but surprisingly enough, the pathologists as well. At first, American pathologists regarded the presence of chronic or sub-acute gastritis only infrequently as in the presence of pyloric obstruction as did Walters and Sebenning in 1931, from the Mayo Clinic. Such conservative sources as the pathologist Paul Klemperer of the Mt. Sinai Hospital in New York, and George Eusterman of the Mayo's, agree now upon the incidence of chronic gastritis with peptic ulcer to be about 67 per cent. These are pathological statistics, and compare very well with the gastroscopic picture. However, it should not be assumed from these findings on the "Post hoc propter hoc"—reasoning, that peptic ulcer is caused by chronic gastritis. It is the old question of "Which came first, the chicken or the egg?" There are those who believe, as does Rudolph Schindler, that the gastritis with peptic ulcer is an associated inflammatory reaction and not the cause of the ulcer. On the other hand we have such experienced observers as Sir Arthur Hurst and Norbert Henning, who believe that chronic gastritis is a forerunner of gastric ulcer. The same controversy is going on regarding the possibility of gastritis as the forerunner of cancer of the stomach.

From our own experience it is quite impossible as yet to commit ourselves definitely on these questions. We must confess that to date we have not yet seen any of our chronic gastritis cases develop into peptic ulcer or gastric carcinoma. Of course, the reason may obviously be due to the fact that all our gastritis cases are promptly placed on a medical regime which embraces our known methods of therapy in chronic gastritis. In this way, it is probable that our patients' stomachs are not given the opportunity of progressing to serious changes.

On the other hand it has been our experience that two forms of chronic gastritis do not appear to improve objectively—i.e. in the gastroscopic picture. These are the hypertrophic, and the non-anemic atrophic forms. However, we have observed that associated edema, congestion, mucus or erosions, with bleeding may disappear on therapy. These latter forms usually respond satisfactorily to

treatment both subjectively and objectively, provided they are not present in the post-operative stomach. The gastritis occurring in the stomach subjected to surgery—seems to be permanent in the majority of cases. This is quite possibly due to the changes in the nerve supply and the circulation wrought by the scalpel, clamp, scissors, and suture material.

THE NERVOUS ELEMENT

Ernst Spiegel, our experimental neurologist at Temple, found that on stimulation of the vagus nerve in the dog, he could produce multiple erosions in the stomach. This would correspond with the erosive or hemorrhagic gastritis in the human subject. In view of the pathologic changes which have been found in the nerve tissue and ganglion cells in these gastritis stomachs, the question of a neurogenic etiology is immediately raised. Symptomatically, we certainly find considerable evidence to support this theory, since many of these patients complain of nervousness, weakness, insomnia, emotional instability, depression, and a host of other equivalents.

Analogies can be made not only in other disturbances of the gastro-intestinal tract such as the spastic colon, "Nervous vomiting or diarrhea", or anorexia nervosa, etc., on a functional basis, but in actual organic disease of the digestive tract as well. This is not infrequently directly traceable to psychic stress and strain, or emotional shocks, etc. It is also well demonstrated by peptic ulcers, which in certain instances appear to spring from a neurogenic basis. For example, peptic ulcer most certainly made a sudden and great outburst in various individuals during the 1929 crash. Harvey Cushing's work on the incidence of duodenal ulcer with brain lesions is in perfect harmony with this concept. It has long been the belief of experienced clinicians, such as Edward Weiss at the Temple University Hospital, that many cases of cardiospasm or pre-ventriculosis have a predominant neurogenic disturbance. In a recent publication he demonstrated his thesis in this respect, but it is important to note that the therapy is a direct medical and mechanical one, involving eso-

phageal dilatation. These cases cannot be treated satisfactorily by psychotherapy alone, as Franz Alexander, the psychoanalyst, of Chicago, believes. It is an instance of the gastroenterologist clinician combining the functions of a psychiatrist in his treatment, usually by indirect methods, suggestion, encouragement, and a sympathetic understanding.

THERAPY

Many cases are due to foci of infection as in the bad teeth, pyorrhea, diseased tonsils or infected sinuses which we so often see. Likewise the pernicious custom of business discussions, arguments, and quarrels during meals, or the gulping of food, inadequate mastication, excessive smoking, alcoholic and dietary indiscretions, etc., are very obvious direct contributory factors in the production of gastritis and should be eradicated. We must not lose sight of the fact also that the stomach is extremely susceptible to extra-gastric influence and lesions of which good examples are disease of the gall-bladder with pyloric biliary regurgitations, and the gastric passive congestion that occurs in heart disease. Therefore the primary focus requires even more intensive management than the associated gastritis. We naturally include the usual methods of nutritious and easily digested dietary with small, frequent feedings and the usual medication employed in the ulcer regime, such as antacid, absorbent powders or preparations, antispasmodics, sedatives, vitamins, iron, digestants, etc. In corroboration of observers such as Eusterman, Comfort, and others, we have found colloidal kaolin in alumina hydroxide one of the most useful adjuvants in therapy in these gastritis patients, particularly when excess acid or mucus is present. A special indication for its use is in those cases where ulcer or gastritis has not responded to alkali medication despite the presence of gastric hyperacidity. Not infrequently we are surprised to find an apparently unresponsive patient with gastro-intestinal disturbances react promptly to colloidal kaolin with alumina hydroxide. In selected instances gastric surgery for peptic ulcer or intractable gastritis can thus be avoided. Comfort of the Mayo

Clinic has recently reported such cases, and this is corroborated by Eusterman in his textbook on "Diseases of the Stomach and Duodenum". We have on various occasions checked the appearance of the stomach through the gastroscope after the ingestion of the colloidal kaolin in alumina hydroxide gel, and found that even after two hours the preparation is still forming a protective coating over the mucosa. It is quite possible that the reason for obtaining better and more prolonged clinical results with this preparation lies in its protective "neutrality" and essentially non-irritant activity. This is in contrast to other chemical substances which cause nerve, secretory, and motility changes in the stomach aside from undergoing systemic absorption. It should not be therefore forgotten that there is such a condition as "Gastritis medicamentosa", caused by indiscriminate and overuse of drugs and active chemical non-absorptive preparations, particularly in the vulnerable stomach.

Gastric lavages with hydrogen peroxide, two per cent are often useful in the management of the atrophic or mucorrhoeal forms, as are the Spa waters. For symptomatic relief, local heat applications and diathermy are good pain relievers. We have used the deep roentgen-ray therapy in three cases of intractable hypertrophic forms of gastritis. This is along the lines of Schindler's application of the Coutard method of intensive high voltage x-ray therapy. We discussed the problem of x-ray treatment in these severe and intractable cases of hypertrophic gastritis with Dr. Chamberlain our radiologist at Temple. It was felt then that the above mentioned therapy was too radical and too little known to use, and that a less intensive and more extended course of radiation should be used. It is obviously too early to draw any conclusions at the present writing although one case has shown objective improvement which was checked by Dr. Jackson and ourselves; the other two are indeterminate so far.

These unresponsive hypertrophic forms, often with ulcerative or hemorrhagic features, are a serious problem to both the gastroenterologist and the surgeon. Not only do they

often show persistent symptoms after the subtotal gastrectomy as performed by the European surgeons; but as some of the Mayo investigators have recently shown in corroboration of the European observers, there are cases that develop gastric malignancy. Similarly, the non-anemic atrophic gastritides are the bane of the gastro-enterologist's existence. These cases not infrequently persist in producing vague symptoms such as gassy distress, belching, nervousness, fatigue, exhaustion, vague abdominal pains, etc. Every clinician is familiar with these so-called "Chronics", who have their ups and downs. We have noted that on many occasions Schindler's observation is true that gastritis patients have a zone of tenderness corresponding to their gastric silhouette, roentgenologically. This can be frequently substantiated by the fluoroscopist who elicits pain on manual palpation of the stomach under the fluoroscopic-screen in patients with gastro-intestinal symptoms. These patients are frequently those in whom negative x-ray and other studies of the gastro-intestinal tract and of the gall-bladder are reported. It has also been our experience that, with the exception of the hypertrophic form

of gastritis, the majority of stomachs with the other forms of gastritis are not diagnosable by the roentgen-ray.

CONCLUSIONS

1. The precaution and constant care in the introduction and use of the semi-flexible gastroscope are emphasized and discussed. Attention is drawn to some pitfalls in instrumentation.

2. Comparative notes are made on the diagnostic interdependency of the x-ray method and the gastroscopic method in the thorough evaluation of diseases of the stomach.

3. The growing acceptancy of chronic gastritis by contemporary authorities in a reversal of opinion is stated.

4. The significance of neurogenic etiologic factors in the gastritis problem is touched upon.

5. Some therapeutic problems and useful points are outlined.

6. The fact is substantiated that patients with chronic gastritis may have tenderness or pain to palpation over the area corresponding to the x-ray gastric silhouette.

4901 North 13th Street

SOME BEDSIDE APPLICATIONS OF CIRCULATORY DYNAMICS

By ARTHUR M. FISHBERG, M.D., New York, N. Y.

Read before the Section on General Medicine of The Medical Society of New Jersey, May 19, 1938.

Heart failure appears under many guises and follows divergent courses. Exertional dyspnea, a nocturnal paroxysm of "asthma", swelling of the ankles, cough, hemoptysis, syncope, abdominal pain, swelling of the abdomen, or other symptoms, may herald the onset of cardiac insufficiency. The subsequent progress of heart failure is equally diverse. For a long time comparatively little systematic investigation was devoted to the elucidation of the reasons why heart failure is manifested so differently in individual instances. That, for example, edema may be the dominant manifestation of cardiac insufficiency in one patient, and be completely absent in another, was known to every physi-

cian, but little progress was made in the explanation of the factors responsible for the difference. In recent years, however, notable advances have been made in the analysis of the pathogenesis of the manifestations of heart failure. It has become evident that several different and well-defined disturbances in the dynamics of the circulation result from heart failure, and that each of these aberrations in circulatory dynamics is reflected in characteristic clinical manifestations. In the following article we shall discuss briefly the characteristics of these individual forms of heart failure, with special reference to the utility of two recently introduced measurement—those of the

circulation time and of the venous pressure—in their differentiation.

THE FORMS OF HEART FAILURE

The primary differentiation in the analysis of heart failure is whether it is due to deficient emptying of the heart (*hyposystolic failure*), or to deficient filling of the heart (*hypodiastolic failure*).

The *hyposystolic failures* include the common forms of heart failure—those due to hypertension, to coronary artery disease, to myocarditis, and to valvular defects. Each of these factors tends to hamper emptying of the heart. Hyposystolic failure may and ultimately usually does involve all the chambers of the heart. Most often, however, it is *initiated* by failure of either the left, or far more rarely, of the right, side of the heart—left-sided and right-sided failure.

The hypodiastolic failures are much rarer than the hyposystolic. Hypodiastolic failure is due to factors which inhibit the diastolic filling of the heart, either through abbreviating the duration of diastole (paroxysmal or other extreme tachycardia), or lessening the diastolic relaxation of the heart (pericardial effusion,—constrictive pericarditis).

It may be pointed out that hyposystolic failure tends to *increase* the size of the heart; while hypodiastolic failure tends to *decrease* cardiac volume.

LEFT-SIDED FAILURE

This is by far the most common form of heart failure. All the frequent forms of heart failure—those due to hypertension, to coronary artery disease, and to rheumatic and syphilitic infection—are almost always initiated by isolated insufficiency of the left side of the heart. That the initial strain in hypertension is borne by the left ventricle is, of course, obvious. The usual onset of the cardiac insufficiency of coronary artery disease in the form of left-sided failure is due to the fact that, presumably as a consequence of the greater thickness of the left ventricle, ischemic damage of the myocardium affects preponderantly the left ventricle and interventricular septum. I have never seen a myocardial infarct involving only the right

ventricle, though this chamber is often implicated in infarcts extending from the left ventricle.

Apart from the rather exceptional occurrence of severe heart failure early in rheumatic fever, the form of cardiac insufficiency in rheumatic disease is almost always determined by the nature of the valvular defects. Since dynamically significant valvular implication is almost always of the mitral and aortic valves, the reason for the usual initiation with left-sided failure is evident. In syphilitic disease, of course, the aortic valve is alone affected.

The clinical picture of isolated insufficiency of the left side of the heart is very simply characterized: It consists in symptoms and signs emanating from engorgement of the pulmonary circuit in the absence of the manifestations—swelling of the cervical veins and liver and peripheral edema—that result from engorgement of the tributaries of the venae cavae. There may also be symptoms due to diminished output of the left ventricle, such as syncope, but these are exceptional unless the onset of the failure is very abrupt.

The outstanding subjective symptom of *pulmonary engorgement* is dyspnea. Investigations of the past two decades especially, and in classical form, by Harrison, have shown conclusively that the outstanding mechanism in the causation of cardiac dyspnea is pulmonary engorgement. Most often the dyspnea is first evident on exertion. But especially in left-sided failure the initial symptom may be a nocturnal paroxysm of cardiac asthma. This is especially likely to occur in individuals who lead a sedentary life, and therefore are not as likely to perceive a relatively small degree of exertional dyspnea during the day.

The dyspnea of *left-sided failure* is particularly apt to be accompanied by *orthopnea*, a manifestation which is likewise due to pulmonary engorgement. Cough is also a common symptom of left-sided failure; it may be accompanied by blood-streaked sputum and rarely by profuse hemoptysis. Left-sided failure may be ushered in by massive pulmonary edema. Cyanosis is rarely pronounced unless there is considerable pulmonary edema.

It has just been mentioned that uncompli-

cated left-sided failure is characterized by pulmonary engorgement in the absence of overfilling of the systemic veins. Regarding the clinical demonstrations of these positive and negative criteria of left-sided failure, the following may be said:

1. The absence of engorgement of the systemic veins is usually readily established by physical examination. The cervical veins are not swollen, there is no peripheral edema, and the liver is not enlarged. These observations indicate that the venous pressure is **not** elevated, an inference that can be substantiated by the simple maneuvers and measurements to be described below in connection with right-sided failure.

2. The existence of the pulmonary engorgement, which is the cause of most of the symptoms of left-sided failure, may be evident from the detection of *moist râles* at the bases or of accentuation of the *pulmonic second sound* which was not previously present. Skillful fluoroscopy usually discloses the presence of pulmonary engorgement. One should look not only for clouding of the lung fields, but also for accentuation and broadening of the hilus shadows, which are almost entirely due to the branches of the pulmonary artery. But especially in early left-sided failure, these objective evidences of stasis in the pulmonary circuit may not be detected despite severe dyspnea and other subjective symptoms.

Objective evidence of pulmonary engorgement may be obtained by demonstration of decreased vital capacity, but this does not help in the differentiation from pulmonary disease, in which the vital capacity is also lowered. Under these circumstances the clinician may be greatly aided by *measurement of the circulation time*, which offers objective evidence of pulmonary stasis, and may immediately differentiate between dyspnea due to heart failure and that due to primary pulmonary disease.

THE CIRCULATION TIME IN LEFT-SIDED FAILURE

By the circulation time is meant the time that elapses between the entry of a foreign substance into one part of the vascular tree, and its arrival at another part. This time is a measure of the velocity of blood flow along the cir-

cuit in question. In the clinical measurement of the circulation time, a substance is injected into an antecubital vein, the arrival of which at some other point can be detected. Perhaps the simplest and most generally useful methods are those in which the substance injected is one that produces a taste when it reaches the tongue. One that has been much used is *decholin*, which produces a bitter taste. We have used *saccharin*, which produces a sweet taste. In health, the saccharin is tasted between nine and seventeen seconds after it has been injected into an antecubital vein. This period measures the time required for the blood to travel from the antecubital vein to the right heart, through the pulmonary circuit to the left heart, and thence to the capillaries of the tongue. Most of this time is required for the transit of the pulmonary circuit.

In left-sided heart failure, there is passive engorgement with slowing of blood flow in the pulmonary circuit, which is reflected in slowing of the arm-to-tongue circulation time. In severe left-sided heart failure the arm-to-tongue circulation time is greatly prolonged; it may even exceed sixty seconds, in which event the velocity of blood flow is less than a third of the normal. With improvement of the heart, the circulation time decreases; it may fall from over thirty seconds to twelve seconds in twenty-four hours as a result of successful digitalization and other treatment.

Perhaps the greatest practical value of the measurement of the circulation time is in the differentiation of dyspnea due to heart failure from that due to other causes, notably emphysema and bronchial asthma. In elderly patients, one is not uncommonly in doubt whether shortness of breath is due to emphysema or to heart failure.

Likewise, the differentiation of cardiac and bronchial asthma, so fundamental for therapy, often presents difficulties. In both these situations the measurement of the circulation time may solve the difficulty immediately. In emphysema and in bronchial asthma, as long as the heart does not give way, the circulation time is normal; while it is prolonged in heart failure.

In *syphilitic aortitis* the measurement of the

circulation time may be useful in deciding whether dyspnea is due to pressure on the bronchi by the dilated aorta, or to left-sided failure due to aortic regurgitation, or narrowing of the mouths of the coronary arteries. When there is doubt whether or not heart failure is complicating pneumonia, and therefore whether or not digitalization is called for, measurement of the circulation time may remove the doubt.

Interestingly enough, measurement of the circulation time almost always yields normal results in at least the vast majority of instances of massive pulmonary edema complicating lobar pneumonia, showing that this redoubtable complication is not due to cardiac insufficiency.

The great practical utility of the measurement of the circulation time is thus evident. It is a method that should be widely used by the practitioner, for it requires no apparatus other than a syringe and some saccharin.

RIGHT-SIDED FAILURE

In the vast majority of instances, right-sided failure is secondary to the primarily left-sided failure of hypertension, coronary arteriosclerosis, or rheumatic or syphilitic disease. The manifestations of the insufficiency of the right ventricle are then superadded to those previously existing as a result of the left-sided failure. We have seen that left-sided failure increases the tension in the pulmonary circuit and thus augments the work of the right ventricle. This and functional impairment of the heart muscle due to coronary artery disease, rheumatic myocarditis, etc., sooner or later lead to failure of the right ventricle in most instances of primarily left-sided failure.

But *primary* right-sided failure also occurs. The most common cause is emphysema or other pulmonary disease which increases the work of the right ventricle. Uncomplicated right-sided failure also occurs in the rare instances of significant disease of the tricuspid or pulmonic valves. Pulmonary embolism may produce acute right heart failure.

Failure of the right side of the heart leads to engorgement of the tributaries of the superior and inferior venae cavae. When well marked, this is usually immediately evident

from the presence of engorgement of the cervical veins, swelling of the liver, and perhaps edema of the dependent parts. Even slight degrees of the overfilling of the systemic veins that bespeaks right-sided failure are usually readily demonstrated by careful observation. If the patient is placed in as close to a recumbent posture as comfortable, the blood column in the jugular veins—which may be regarded as manometers connected with the right auricle—does not rise above the horizontal plane passing through the manubrium sterni when the venous pressure is not elevated. And if the hand of a subject with normal venous pressure is slowly lifted, the veins on the dorsum collapse within less than eight cm. above the level of the heart. On the other hand, if there is engorgement of the systemic veins, the height of the jugular blood column is greater, and the hand must be lifted higher to occasion collapse of the veins.

Help in the differentiation of right heart failure is often obtained by observation of the cervical veins following pressure on the right upper quadrant of the abdomen while the patient continues breathing quietly. If there is overfilling of the veins due to right-sided failure, such pressure results in swelling of the cervical veins. Contrariwise, in the absence of heart failure, even though there is ascites or enlargement of the liver due to cirrhosis or malignant growth, pressure on the right upper quadrant does not occasion swelling of the cervical veins.

THE MEASUREMENT OF THE VENOUS PRESSURE

In individuals in whom the superficial veins are not plain, the foregoing maneuvers may fail. And at best they afford only qualitative information. For the more precise investigation of the state of repletion of the veins, measurement of the venous pressure is necessary. This is a very simple procedure. All that is needed is a right-angled glass tube attached to an eighteen-gauge needle. The arm of the recumbent patient is placed so that the antecubital vein is at the level of the right auricle (five cm. posterior to the sternum in the fourth interspace); and the needle inserted in the vein. The height to which the blood rises is the venous pressure in centimeters of water. In

health the venous pressure by this method is less than eight cm. of water. In right-sided failure the venous pressure rises, sometimes to more than thirty cm. The measurement of the venous pressure is of great practical utility, and should find wide application by the practitioner.

Perhaps the most important diagnostic aid that can be obtained from measurement of the venous pressure is in the sometimes troublesome differentiation of enlargement of the liver or ascites due to heart failure from those due to cirrhosis or neoplasm. In the latter instances the venous pressure in the arm is normal.

There is a significant exception to the rule that engorgement of the systemic veins and increase in venous pressure bespeak right-sided failure. In emphysema, as a result of the elevation of the intrapleural pressure due to the diminished elasticity of the lung, the veins may be engorged, and the venous pressure may rise to as much as fourteen cm. even though cardiac insufficiency is absent, as revealed by normal circulation time. That compression of the superior vena cava by mediastinal or other masses may cause elevation of the pressure in the antecubital veins goes without saying. Here, contrary to heart failure, the liver is not engorged.

Finally, attention should be called to the seemingly paradoxical fact that in extreme insufficiency of the right heart, usually preterminally, the pressure in the veins of the extremities may fall. Indeed, under these circumstances, the veins of the extremities may be so empty that it is difficult to introduce a needle into them; and when the pressure in the antecubital vein is measured it may be found little above zero.

Not uncommonly, one observes the following sequence of events: As a result of right heart failure due to arteriosclerotic or valvular disease, the veins of the extremities are engorged, and the pressure within them is high. Then the patient becomes worse and is obviously nearing the end. As this occurs, the engorgement of the veins in the extremities lessens, and the pressure within them falls from its previously high level until it becomes preternaturally low.

A clue to the mechanism of this frequent fall in peripheral venous pressure in the terminal stages of right heart failure is afforded by comparison of the pressures in the jugular and the antecubital veins. This shows that as the antecubital pressure falls, the tension in the jugular veins is much less or not at all affected, and may remain high despite the fact that the veins of the extremities are completely collapsed. The explanation of this fall in the pressure in the antecubital veins, while that in the jugular is unaffected, would seem to be vasoconstriction in the extremities. In the most extreme degrees of heart failure, the volume of blood pumped by the heart falls to such low levels as to be insufficient to supply adequately the whole organism. Under these circumstances, the small vessels in the extremities are constricted, with the result that the small cardiac output is almost entirely diverted to the central nervous system, heart, and other immediately vital parts. In the exceptional instances in which the patient survives with such a small cardiac output for sufficient time, the vasoconstriction in the extremities may lead to gangrene of the fingers and toes (and also of the tips of the nose and ears). This would seem to be the explanation of the remarkable symmetrical gangrene that sometimes occurs in cases of ball-valve thrombus of the left auricle complicating mitral stenosis—the condition in which the most extreme reduction of cardiac output consistent with more than momentary survival occurs.

HYPODIASTOLIC FAILURE

The recognition of the form of heart failure due to interference with the diastolic relaxation of the heart has recently assumed greater clinical importance because of the splendid results obtained by operative treatment in constrictive pericarditis. In this condition the usual clinical picture is that long known as *Pick's syndrome*, and dominated by recurrent ascites and enlargement of the liver, while the manifestations of pulmonary engorgement are generally relatively slight.

In the differential diagnosis from Laennec's cirrhosis, the measurement of the venous pressure may be of decisive importance. In Laen-

nec's cirrhosis the pressure in the antecubital veins is normal, in constrictive pericarditis high.

In the differentiation of constrictive pericarditis from other forms of heart failure, the measurement of the venous pressure may also be very helpful. It is characteristic of many cases of constrictive pericarditis that the venous pressure stays at an almost constantly high level despite great fluctuations in the clinical course. Thus, bed rest, mercurial diuretics, and other measures may lead to diminution or disappearance of the ascites, but measurement of the venous pressure shows little change. This is, of course, due to the fact that the elevation of venous pressure results from the mechanical obstacle formed by the pericardium. On the other hand, fluctuations in heart failure due to endocardial or myocardial disease are generally accompanied by corresponding changes in venous pressure.

SUMMARY

The attempt has been made to summarize for the practitioner some of the bedside applications of recent advances in knowledge of circulatory dynamics.

Especial stress has been laid on the analysis

of the clinical pictures of heart failure from the point of view of the underlying aberrations in the dynamics of the circulation which produce the symptoms.

The clinical manifestations of left heart failure, of right heart failure, and of hypodiastolic heart failure are described.

The clinical importance of measurement of the circulation time and of the venous pressure—by methods requiring no complicated apparatus and suitable for the general practitioner—is pointed out.

Prolongation of the circulation time is a delicate index of failure of the left side of the heart. The measurement of the circulation time is of especial value for the differentiation of cardiac and pulmonary disease.

Elevation of venous pressure is an indication of failure of the right side of the heart. Measurement of the venous pressure is often decisive in the differentiation of heart failure from cirrhosis of the liver and other conditions producing enlargement of the liver or ascites.

Fixation of the venous pressure at a high level, despite fluctuations in the ascites and other symptoms, occurs in constrictive pericarditis.

1136 Fifth Avenue

A LESSON FROM A DEATH CERTIFICATE

NUMBER SEVEN

Patient, aged thirty-six years; para xii; weight 231 pounds.

Previous labors uncomplicated. Cesarean elected in order to tie off tubes at same time. Operation delayed unexpectedly. Patient under ether two hours. Forty-eight hours later showed signs of pneumonia. Died three weeks later.

Is cesarean justified with no other indication

than to sterilize the patient? It saves another period of hospitalization, but adds a greater risk.

The risk of doing a hysterotomy for a therapeutic abortion and sterilization should also be carefully considered before it is attempted. It may result in loss of a life.

A. W. BINGHAM, M.D.

SYPHILIS AS AN OBSTETRIC PROBLEM

MATERNAL WELFARE ARTICLE NUMBER THIRTY-FIVE

By HENRY B. KESSLER, M.D., Newark, N. J.

Read before the Section on Obstetrics and Gynecology at the 172nd Annual Meeting of The Medical Society of New Jersey at Atlantic City, N. J., May 18, 1938.

The medical profession has realized for a long time the necessity for the control of syphilis, but it is only recently that the public has become sufficiently concerned to coöperate with us. In view of this change in attitude, a survey of our present knowledge of this disease is both timely and advisable. I shall, therefore, attempt a brief review from the obstetric standpoint.

Early in this century, all within a period of a few years, the pathogenesis of syphilis was discovered, the method of diagnosis developed, and the therapy formulated. Despite this, the incidence has continued to increase until the infection has become the most prevalent among transmissible diseases. Being hereditary as no other disease, and affecting every tissue and organ of the body, it is far-reaching in its effects. Untreated or improperly treated victims of the disease are in great danger of the destructive processes so undermining their health as to render them useless members of society, and a costly burden to the community.

Every branch of medicine is concerned with the problem of syphilis. On the obstetrician falls added responsibility; for two lives are involved—the mother and her offspring. It is Usilton's belief that there are approximately 186,000 potential mothers in this country with active syphilis.¹ According to another estimation,² from three to five per cent of pregnant women are syphilitic. Fetal and neonatal deaths among the offspring of syphilitic mothers are greater than among those of nonsyphilitic mothers, syphilis being the most frequent cause of fetal death. Of the children born alive of syphilitic mothers, many die soon after leaving the hospital, and many more to whom the infection is transmitted are stigmatized and are not free from the effects of the disease from the beginning to the end of life. Such a picture of appalling human catastrophes is a challenge, and should impress us with the fact that

no effort should be spared to solve the problem of syphilis in obstetrics. Beyond a doubt, this is the greatest opportunity to practice preventive medicine.

Let us refresh our minds as to how the infection is transmitted from parent to offspring. The period when infection occurs has a bearing on pregnancy. The prospective mother may acquire syphilis before conception, at conception, or during the time of gestation. Fluctuations in the intensity of the maternal infection, the varying virulence of the spirochetes, as well as their presence in the mother's circulation, affect the outcome of pregnancy and the condition of the offspring. The opinion today is that infection from mother to baby usually takes place after the sixteenth week of intrauterine life.³

Infection of the fetus occurs only by the spirochetes which circulate in the maternal blood entering into the chorionic villi. The organisms gain access to the fetus from the placenta through the umbilical vessels or lymphatics.

There has been some belief that the infection can be transmitted from the father to the ovum directly, without the mother becoming infected. This is questionable. The general opinion is that transmission to the offspring is only by infection through the mother, although she may give no history and show no evidence of the disease. If the course of the disease has run for a prolonged period and is dormant, there is less chance of transmission to the offspring.

When the disease is contracted late in pregnancy, transmission is not likely even though treatment has been insufficient, unless the disease is localized in the birth canal.

When early manifestations have disappeared, syphilis may pass into a quiescent stage for an indefinite period. Clinical latency in the prenatal patient was observed in 83.5 per cent of 243 cases studied by Speiser.⁴ Still it must be

borne in mind that the disease may be at work in the body during the latent stage—"the spirochete hidden in silent areas, temporarily inaccessible to therapy, but nevertheless irritating the tissues and producing a persistent rearrangement of the microscopic anatomy".⁵

Let us consider how the disease manifests itself in a pregnant woman. A married woman who has syphilis frequently gives a history of abortions, premature deliveries, and stillbirths. If as the outcome of a later pregnancy she succeeds in giving birth to a full-term child which lives, it has snuffles and shows a positive serological reaction. In certain cases, verification may be possible by physical and serological examination of the husband and the other children. When the occurrence of repeated late abortions or stillbirths cannot be readily explained by toxemia or the traumatism of labor, syphilis should be suspected.⁴

Pregnancy in itself usually does not produce variation in the disease. According to some authorities, there is a tendency for the clinical manifestations of syphilis to be repressed in pregnant women, and they are said to be absent in some cases. However, in patients in whom definite manifestations of the disease exist, they vary from those in syphilitic nonpregnant women and are distinctive. The initial lesion is more marked, and requires a longer time to heal. In the cervix the normally soft tissue is in contrast to the luetic induration. Cervical chancres, usually oval in shape and of the erosive type, form fissures radiating toward the cervical canal. The chancres are more deeply red in contrast to the blue-tinged cervical tissue, are friable and bleed easily.⁶ More prominent mucous patches are present. Secondary symptoms, especially on the genitals, appear earlier, are often exuberant, and undergo suppuration. Point further adds: "Eroded papules develop rapidly, undergo progressive hypertrophy, and often constitute veritable granulation tumors which invade and deform the entire vulva." There may be late manifestations such as "the presence of unexpected scars, leukoderma, periostitis, unaccounted-for paralysis, altered reflexes, pupillary irregularities"; Argyll Robertson pupils and aortic disease also being of

diagnostic value.⁴ The patient is likely to complain of severe headache, insomnia and bone pains.

In the active stage, pregnant syphilitics likewise show additional subjective symptoms such as sore-throat; and joint, muscle, and nerve pains. Symptoms referable to various organs undergo later changes characteristic of syphilis. Intrauterine life may no longer be felt.

However, danger lies in the fact that syphilis is an extremely deceptive disease in women, and its early manifestations are apt to be so obscure, due to structural anatomy, that they are not considered serious, or they escape detection entirely. Exner claims that about half the people who have syphilis do not know they have it.⁷ This failure to detect the disease can be largely overcome if more emphasis is placed on the routine serological examination of pregnant women. Both a Wassermann and one of the flocculation examinations, such as the Kahn or Kline diagnostic, should be made, preferably before the fifth month and again at the eighth month. Although serological tests cannot be depended upon absolutely, when properly done they are just as reliable during pregnancy as at any other time.

A *negative reaction* does not necessarily indicate absence of the disease. In latent periods, and in the tertiary stage, the reaction is likely to be negative. In the syphilitic pregnant woman a negative reaction, produced either by latency or treatment, greatly increases the chances for a living, apparently nonsyphilitic child.⁸

A *positive blood reaction* during pregnancy indicates a serious prognosis for the fetus. In an analysis of numerous cases, Cole and his co-workers found that ten times as many syphilitic children were born if the mother's blood was positive during pregnancy as when it was negative.⁹

There may be a questionable positive reaction without syphilis being present. In disorders during pregnancy, such as scarlet fever, malignant growth, tuberculosis, puerperal sepsis, and eclampsia, the Wassermann reaction may be positive. These false positive reactions can be ruled out by doing both types of serological examination. Repeated strongly posi-

tive reactions by both methods are indicative of syphilis. The significance of the serological test differs in the three stages into which the disease is usually divided. In the early first stage the darkfield examination is of much more diagnostic value.

Furthermore, each stage of syphilis varies in its influence on pregnancy.¹⁰ In the *primary stage*, inoculation occurs when the spirochetes gain access at the portal of entry.

If infection and fecundation occur simultaneously, the embryo—if it develops at all—will likely die. If infection follows fecundation, the length of the interval between the two occurrences will determine the fate of the embryo or fetus.

If infection takes place in the last month of pregnancy, the infant may possibly escape contamination. It is more likely, however, that the disease will manifest itself in a syphilitic child within two months following birth. Such an infant if untreated usually dies of the disease shortly after birth.

Conceivably, vigorous fetuses which become infected in the seventh month may run through the early secondary stage *in utero* and be born free from signs of syphilis. Offspring thus infected make up the group of congenital syphilitics who remain without symptoms of the infection until late in childhood, or even during or shortly after adolescence.

In the *secondary stage* the spirochetes disseminated throughout the body give rise to a generalized florid condition. There is evidence of involvement of every organ and tissue. This period begins about the time the initial lesion resolves, or shortly afterward.

The duration of the disease, and whether or not a stage of activity or latency exists at the time of gestation, modify the course of the disease in the offspring. The older the secondary stage, the longer are the periods of latency, and the shorter are those of activity. We must assume that during activity the circulating blood contains a great many spirochetes, while during latency few or none are present.

In the *tertiary stage* the infection becomes increasingly limited. Activity is more localized. Recurrently or constantly the disease manifests

itself in one organ, or a restricted class of organs and tissues.

If during the entire gestation the disease is in an inactive state, the offspring is not likely to be infected. However, if the few spirochetes present enter the circulation during apparent latency, infection of the offspring is conditional on the simultaneous presence of several factors:

First, the organisms must enter the uterine circulation.

Second, they must be viable enough to reach the chorion or placenta.

Third, they must then be sufficiently viable to gain a foothold and multiply. The embryo being fresh soil, the possibility, or even the probability, is that the organisms will become more viable.

In the presence of syphilis in a pregnant woman there are considerations which are absent in ordinary pregnancy. Labor may not differ from that of women in good health. On the other hand, it may be definitely affected. Uterine contractions may be weak. Abnormal presentations are common, and precipitate labor may occur. An active form of the disease may give rise to edema of the cervix. In some cases local lesions produce cervical tissue changes, resulting "in marked resistance to dilatation to the degree of actual advanced dystocia, with marked tendency to cause deep cervical lacerations at delivery. If syphilitic granuloma is present, it may cause enough obstruction to block delivery, while condylomata lata usually cause such friability of the perineum that it tears like wet blotting paper."¹¹ Cicatricial stenosis from healed ulcer of the cervix may impede labor and may even require incision of the cervix or Cesarean section.

Perineal repairs should *not* be made immediately after delivery; but later, when healing has taken place.

Syphilis as a complication in obstetrics is grave for the mother, as puerperal morbidity is more common than in nonsyphilitic cases. Nephritis, eclampsia, and sepsis are more likely to occur. During labor such complications as premature detachment of the placenta and exhaustion of the adrenal system may occur with fatal results, though not often. Adherent pla-

centa frequently occurs. Subinvolution, rarely hemorrhage, and delayed recovery may result.¹¹

Contrary to the view generally held, the disease plays a very small part in early abortion; but if untreated, it may cause late abortion or premature labor.

The effects of syphilis on the product of conception vary with the severity of the maternal infection, and the amount of treatment received. The majority of fetal deaths occur between the fourth and fifth months of pregnancy, being due, according to McCord¹² and Browne,¹³ to failure of adequate blood supply produced by closure of placental vessels. Interruption of pregnancy takes place commonly at the fifth, sixth, and seventh months. According to Heynemann, Spalding, Huermberger, and others,¹¹ more than 60 per cent of the cases show late abortions, and untimely expulsion of macerated fetuses. A dead fetus in the later months of pregnancy may or may not give evidence of the disease.

After mid-pregnancy *Spirochaeta pallida* may be demonstrated in the blood and organs of the fetus; most commonly in the adrenals, less frequently in the lungs, and still less so in the pancreas, liver, and internal glands.

If the signs of luetic infection are present, they are characteristic.

Uterine death of the fetus is frequently associated with maceration, the skin having a tendency to peel easily. Maceration of the skin, however, should not be considered as a particular sign of syphilitic infection, for it is evident to some extent in any dead fetus after long uterine retention.

Besides the interstitial tissue changes in the above-mentioned internal organs, *osteochondritis* is present in the long bones, a pathognomonic sign of congenital syphilis.¹⁴ The changes characteristic of osteochondritis are evident in macroscopic, microscopic, and radiographic examination.

In the *umbilical cord*, changes in the walls of the veins are indicative of syphilitic infection, the muscular coat and the intima being thickened and edematous. The connective tissue stroma undergoes alteration. The lumen of the vessels is reduced, and round-cell infiltration is evident.

When the fetus is dead, the cord is edematous and the vessels plainly visible. Wharton's jelly may be absent. The amniotic fluid may be increased.

In 70 per cent of all cases of syphilis in pregnant women evidences of the disease are found in the placenta, even when the child is without visible signs. The disease possibly exhausts itself on the placenta, and so the fetus becomes only slightly affected. A suggestive sign of the disease is the relatively greater proportion of the size of the placenta to that of the child.

McCord¹⁵ made a study of 1,085 placentas of mothers with strongly positive blood Wassermann reactions, in an effort to evaluate the histologic diagnosis of placentas at all stages of pregnancy—those of stillborn babies, as well as of babies born alive. The diagnosis of the syphilitic placenta was attempted only along well-established lines, namely: the enlargement and crowding of the villi; the presence of connective tissue in varying degrees of density; an increase in stroma cells; and a lessening or the absence of the vascular supply of the villi.

This study shows that the antisymphilitic treatment of pregnant women has some definite influence on the histologic appearance of the placenta. Furthermore, "The more distant from term, the greater is the difficulty in making a histologic diagnosis of syphilis of the placenta. Dead babies seem to increase this difficulty, regardless of the duration of the pregnancy."

In addition to histologic examinations an umbilical cord serological test should be made. This is not absolutely reliable, often due to the unsatisfactory condition of the specimen. In the vast majority of cases a strongly positive serological reaction, properly done, means that the baby has congenital syphilis. A negative cord Wassermann reaction is no indication that the baby is not syphilitic.¹⁴

Results show that, in women brought under treatment by mid-pregnancy, that is, receiving treatment over a period of five months or more during gestation, about 95 per cent of the offspring will be protected.¹⁶ Treatment begun at any time after mid-term will still serve to protect a surprising proportion of children from

infection before birth.¹⁷ In a series of 617 pregnant women, Paley¹⁸ found that even a moderate amount of treatment increases the percentage of nonsyphilitic babies from 53.7, to 77.62 per cent. Even late inadequate treatment may mean a living, possibly a nonsyphilitic child.

Offspring born of untreated syphilitics during the first years of the course of the disease are almost invariably infected. Of infected children only 15 per cent reach full term; of these, 67 per cent are stillborn or die within the first days of life.¹¹ "Babies born of Wassermann-positive mothers are hazardous propositions, and only prolonged observation should convince one that they are free of the disease."¹⁹

The appearance of the syphilitic child varies materially according to whether it is born alive or dead. In either instance it is markedly undersized. The subcutaneous fat is reduced or entirely lacking.

Distinct manifestations of the disease may be seen in the live infected child. The presence of cutaneous disorders such as roseola, papules, and blebs leaves no doubt of the diagnosis. The skin is usually dry, brittle, and drawn, and has a peculiar grayish or greenish hue. At the flexor surfaces of the joints the skin is especially brittle, and abrasions readily occur, exposing the underlying corium. On the soles and palms, the skin is thickened and glistening, and in some cases shows pemphigoid vesicles. A copper-colored erythema of the buttocks, paronychia, lymphangitis, and icterus have been noted by De Lee.²⁰

Speiser²¹ reminds us that there is a possible transfer of complement fixation substances, or reagin, to the child, resulting in a temporary false positive blood reaction. If the baby is free from syphilis within the first two months of life, the blood reaction becomes weaker and eventually is negative.

If the child escapes syphilis before birth, it may become infected while it is passing through the birth canal, or later by nursing. Provided a mother in the latent stage of the disease has *antibodies*, she can nurse her child without grave danger of it becoming infected.

Active infection in the mother precludes nursing of her child who has been proved free from infection. A syphilitic baby is a source of infection to a wet nurse.

The outlook for the mother and child is better, the earlier syphilis is diagnosed and treatment is started. The course of the disease is modified by the therapeutic agent aiding the natural combative forces of the body in destroying the invading organisms.

The optimal time for introduction of treatment is in the primary stage, before the serologic reaction is positive. In the study made by Cole and his co-workers, the fact that the mother's syphilis has reached the latent stage before conception did not alter the necessity for protecting the child through treatment given during pregnancy.

Treatment should not be controlled by the serologic reaction. It should be given cautiously, and should be modified in the presence of complications. Antisyphilitic treatment is tolerated by the pregnant woman, as well as the non-pregnant. Therefore, the nature of treatment does not differ essentially from that of any ordinary adult in the corresponding stage of the disease.²² She should be advised to observe the usual rules prescribed for prenatal care.

There is evidence that habitually aborting syphilitic women are capable of giving birth to living, apparently nonsyphilitic children when they have been given specific treatment throughout pregnancy.

Even though the child has already become infected *in utero*, treatment of the mother should be pursued diligently not only for her own sake but because it also constitutes early treatment of the infected child, thus affording a far greater chance of cure when treatment is continued after birth.²³

Following delivery, the patient should be impressed with the necessity of continuing treatment if a "cure" or arrest of the disease is to be obtained.²⁴

A woman once having had syphilis should be treated during every pregnancy, even if her disease appears to be under control, and regardless of what her blood may show. Treat-

ment in a preceding pregnancy fails to influence the outcome of a subsequent pregnancy.

Because another problem of a sociological nature is involved, we may be unable to eliminate syphilis to the extent that we have smallpox, cholera, and typhoid; still much can be done. When it is realized that women can transmit the infection to their offspring for any number of years after acquiring the disease, the need of encouraging the patients to be optimistic, and persist in treatment becomes obvious.

In the Scandinavian countries, where reporting of cases and treatment are compulsory, the greatest progress has been made in the control of the disease. The results where a voluntary system is in operation, as in Great Britain, progress has not been as satisfactory but the number of cases has declined.

Though in our country, so extensive in area and with its much larger population, the problem of control is far more difficult than in these smaller countries—it can be solved.

Let us note a progressive step in our State. Legislation in New Jersey has been very recently enacted to make serological examination for syphilis compulsory in application for marriage license and in every case of pregnancy.

A program of action for the control and eradication of syphilis in general, also applies to the disease as an obstetric problem. Certain

measures should be included in such a program, namely:

1. All cases must be found.
2. No publicity should be entailed in reporting cases.
3. Assistance from public health departments should be augmented.
4. Laboratory facilities should be improved. No antepartum clinic can be regarded as being in line with modern ideas and practice which fails to make serological examinations as a routine in all pregnant women.
5. Proper free treatment should be made available for the indigent.
6. Physicians should be prepared to give adequate treatment.
7. Accurate and adequate records should be kept.
8. Patients should be kept under closer observation and over a longer period of time; and in case of children born of syphilitic women, follow-up should be more thorough than at present.
9. Prevention of new cases and infection of others must be pursued with vigor and persistence.
10. Lastly, and perhaps most important of all, the public must be educated more fully to an appreciation of what can be done.

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THE PRESIDENT'S PAGE

NUMBER TEN

THE SURVEY OF MEDICAL SERVICES

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

An address before the Welfare Committee, February 19, 1939

The Federal Government has a National Health Program. The doctors of America must either accept it as it is; or reject it altogether; or attempt to modify it by the addition of desirable supplements or by the elimination of those phases which are inimical to public welfare.

RESULTS OF ACCEPTANCE

If American Medicine accepts the National Health program in toto, we accept, among other things, an expensive and probably unnecessary *hospital-building program* based on an inaccurate survey from which the erroneous conclusion was drawn that 17,000,000, or 11 per cent, of the American people are more than thirty miles removed from a general hospital. As a matter of fact, less than one and a half per cent of Americans are more than thirty miles removed from a general hospital.

If we accept the National Health Program in toto, we accept *Compulsory Health Insurance*. The House of Delegates of the American Medical Association is unanimously opposed to compulsory health insurance because it means the inevitable politicalization of medicine here as it has elsewhere. Compulsory health insurance may come in spite of us, but not with our consent. Indeed, organized medicine is now struggling to escape from a dramatic and unprecedented shotgun wedding staged by the Department of Justice. If compulsory health insurance is born out of wedlock, there will be dystocia, and the offspring will be an acephalic monstrosity. No, we cannot accept the National Health Program lock, stock, and barrel, and remain true to ourselves, true to the traditions of American democracy, and true to those unfortunates,—the sick of the land who look to us, and not to politicians and theorists, for health counsel and guidance.

RESULTS OF REJECTION

On the other hand, if American medicine rejects the National Health Program altogether, the American public will be deprived of expanded public health facilities which are sorely needed, and the medically indigent will be *deprived of help which* is an urgent exigency.

RESULTS OF MODIFICATION

If only the National Health Program could be stripped of those few features which are extravagant and un-American, we believe that future generations would regard it as one of the great human documents of all times. We would not reject all of the plan if we could; and could not if we would. Rejection implies resistance, active or passive. Active resistance requires more unity, more organized strength, and less individualism than the medical profession now possesses. We have neither the vocal capacity nor the voting strength of labor unions, although through our patients, potentially, we have more. Passive resistance means strikes,—sit-down or perambulatory,—both of which are unthinkable.

Last Fall we entertained high hopes of a workable compromise. Seven practicing physicians were appointed to confer with the Interdepartmental Committee and its technical advisers. We hoped that reason would rule. At the time, however, we foresaw that, if compromise and conciliation failed, medicine would have to campaign for the good and against the bad features of the National Health Program. Moreover, we realized that, if the call to arms came, the conflict would occur in the fields of public opinion and in the halls of Congress. Fortunately, some other State Societies as well as The Medical Society of New Jersey have well-planned public relation programs, and have made opportune contacts with their Senators and Representatives. The present Congress is showing heartening signs of independent thought and action.

NORTHWEST REGIONAL CONFERENCE

Your President attended the *Northwest Regional Conference* a week ago in Chicago, and came away discouraged and disheartened over the national situation. In New Jersey our relations with the Chief Executive, and with his Health and Welfare Advisory Committee, with the various Departments of State, with the law-makers, and with the public, are fine. It is discouraging and disheartening to have to report that the relations between organized medicine of America and the advisers of the Chief Executive lack the mutual good will and understanding which exist here in New Jersey.

The Northwest Regional Conference met in Chicago on February 12, 1939. This conference has no constitution, no by-laws, and no dues; but once a year for the last seven years, progressive leaders in medicine, representing some sixteen states,—mostly of the Upper Mississippi Valley,—have met informally to discuss medical economics. No one knows why it is called Northwest, unless it meets at some point northwest of some other point southeast. It is not a legislative body, but rather a settling reservoir.

The highlights of the program were as follows:

1. Statewide Hospitalization Plan for the Low-Wage Group—Roy McCarthy, of St. Louis.
2. Pennsylvania's Public Assistance Program for the Medically Indigent—Walter Donaldson, of Pittsburgh.
3. Middletown Modernizes Medicine—A lantern demonstration from Muncey, Indiana.
4. The Physician's Role in the Public Health Program—Theodore Mayer, of St. Louis County.
5. The National Health Conference—Henry A. Luce, of Detroit.
6. Survey on the Need and Supply of Medical and Hospital Care—William F. Braasch, of Rochester, Minnesota.
7. Supplementary Arrangements for Medical Care—R. G. Leland, Chicago.
8. Kansas Can Control Cultists—Clarence Munns, of Tokepa, Kansas.

Your President is transmitting excerpts of each discussion to our own committees.

Two of the subjects are of particular interest to the Welfare Committee. The first of these is a report on the National Health Conference by Dr. Luce (No. 5 of the program), President of the Michigan State Medical Society, and one of the seven practicing physicians appointed by the House of Delegates of the American Medical Association to confer with the Interdepartmental Committee and its technical advisers.

Dr. Luce stated that he and his six confreres had hoped to sit down at a table to discuss matters with the federalists and to arrive at conclusions which would be the result of the thinking of the whole group. *The doctors were kindly received in Washington; but that was all.* The Government had laid its plans, and they were immutable. Nothing could be done about it. I continue to quote Dr. Luce, although not verbatim:

Sometimes they listened to us, and sometimes they did not. Dr. Donaldson tried to tell them about the impressive work done in Pennsylvania. They were not interested in any plan except their own. We were called back to Washington on January

15th. The newspapers stated that we asked⁶ for a conference with the President. We did not. Neither the October nor the January conference was at our request. We were invited to each. And we left Washington depressed and frustrated. The only good that came out of the conferences was the fact that organized medicine demonstrated to the public a willingness to confer; and that did some good.

On January 23, President Roosevelt sent his message to Congress. He recommended the report of the Interdepartmental Committee to Congress for study. A year ago this would have been "you-must" legislation.

I continue to quote Dr. Luce:

The President's report began with this statement: "There can be no doubt that the general level of health in this country is higher than at any time in its history", and yet seventy-one pages follow in an attempt to change the system of medicine which made this statement possible.

So many alluring things were in the report that if I were a Congressman I would say, "Fine!"

Senator Vandenberg told Dr. Luce that he was opposed to the expenditure of all this money—that the United States was already spending \$15 for every \$8 taken in, but that he did not know the attitude of the doctors. Medicine's only hope is in educating the legislative, rather than compromising with the executive, branch of the government.

Trout flies are attractive to trout, but under the feathers is a hook. The *feathers*, according to Dr. Luce, are federal funds to aid states in their programs; but the *hidden hook* is the proviso that these programs must meet federal requirements.

The health message of the President is now in the hands of the Ways and Means Committee. Senator Wagner has not yet introduced the National Health Program under a bill which is to bear his name. When the issue comes up on the floor, organized medicine will have to present *facts,—instead of fancies, theories, and general impressions,—*to Congress.

THE W. P. A. SURVEY

The foundation upon which the whole superstructure of the National Health Program rests is the statement that *one-third of our population is now without adequate medical care.* This statement is made on a fragmentary survey by W. P. A. statisticians, working under the Federal Government's Technical Advisory Committee. These W. P. A. investigators went to homes, shook hands, and asked a few perfunctory questions. The canvassed population was drawn from eighty-three cities and twenty-three rural areas, in eighteen states; and included 2,250,000 people, of whom 429,000 were

members of families on relief, and 562,000 belonged to the marginal income class above relief level. Even if this is a fair cross-section of America, and even if adequate care means the best room in the hospital, four certified specialists, and three pasteurized nurses, the conclusion is still incorrect,—that 40,000,000 Americans are without adequate medical care.

You and I know that only two per cent of the people are ill at any one time. For the sake of argument, let us admit that 40,000,000 Americans do not receive adequate care. Two per cent of 40,000,000 is 800,000. According to W. P. A. figures then, only 800,000 are without adequate medical care at any one time. But you and I know that 20 per cent of the people, when ill, do not consult physicians, because of ignorance, or fear, or because they prefer quacks, cults, chiropractors, faith healers, Christian scientists, etc.; and some are too proud to ask for charity.

If we deduct this group from the 800,000, there are then, according to federal figures, 640,000 Americans at this moment who are without adequate medical care. On the anniversary of the founding of The Medical Society of New Jersey, its present officers spoke over every radio station in the State and asked anyone who knew of an individual who could not receive adequate medical care to notify the executive office in Trenton. This statement was published in every newspaper in the State. To date 153 letters have been received, and there are four million people in New Jersey! These letters were referred to the County Societies, where it was found that adequate medical care was available for all of them, except one woman in Middlesex County who wanted a criminal abortion.

THE NEW JERSEY SURVEY

Some of us doubt then that 1,333,000 of New Jersey's 4,000,000 people are without adequate care. As a matter of fact, our survey indicates that adequate medical care is available for more than 95 per cent of the people, and that active and energetic attempts are now being made to correct the defects in distribution.

The A. M. A. survey met with active and passive resistance within the profession. For example, Dr. Cabot, of the Mayo Clinic, at a widely publicized hearing in Washington asked, "How can doctors know how many people do not receive adequate medical care because these very people do not go to doctors?" On the face of it, the question seems reasonable; but Dr. Cabot forgot, or never knew, that the survey included studies by nurses, druggists, den-

tists, hospitals, dispensaries, welfare workers, indeed everyone who came into contact with the sick.

Several State Societies refused to coöperate. One gave up in despair. Fortunately the House of Delegates of The Medical Society of New Jersey authorized an expenditure of a sum of money not to exceed \$1000 for our own survey. It was fortunate because, when Governor Moore turned to the Medical Society for leadership in his State health and welfare work, we were prepared.

Then there was passive resistance by doctors themselves who do not like questionnaires. Altogether there were four blanks, three of which were for the individual doctor to fill out,—the 1 F. forms. The total time necessary for this work was less than one hour. In France and Germany, under politicalized medicine, every doctor whether he likes it or not spends between two and three hours every day in filling out fifty-nine forms.

Dr. Braasch, Chairman of the A. M. A. Survey Committee, at the Regional Health Conference last week, reported the status of the survey as of February 8th. In the United States 328 counties had completed their surveys, in thirty-two states, over an area which covered 17,000,000 people. Dr. Braasch believes that the Medical Survey will have a coverage of approximately 20 per cent. It must be completed by February 28th. It is likely that doctors who send in their income tax blanks at the last minute will also wait for the eleventh hour to turn in their survey questionnaires. No one ever hoped, however, that the survey would be complete. "The medical profession at large has failed to recognize the importance of the survey," said Dr. Braasch. Every going concern has an annual inventory, and organized medicine must have some sort of an annual survey of its own.

The national survey, incomplete as it must inevitably be, will give a far more accurate picture of the supply and need of medical services than any survey heretofore made. It will act as a guide in the improvement in the distribution of medical care, and will demonstrate to the public that organized medicine is now, as always, altruistic. Moreover, it has already produced close coöperation between allied agencies and the profession.

I am happy to report that the survey in New Jersey is much more revealing and inspiring. All of our counties, save four, have already turned in their data. The information varies in completeness, as one might expect. Hudson County went beyond the questionnaire of the American Medical Association, and submitted

a report more understandable, to New Jersey-men at least, than was possible by just answering the original questionnaire.

Assistant Executive Secretary of The Medical Society of New Jersey, Dr. Scott, gathered information from the four delinquent counties, so that the New Jersey report by counties will be 100 per cent. As for the individual I F. forms, we have received 2,000 replies from the last of these. As for State agencies and allied

groups, our State survey will be complete, and we will have spent less than \$600 of the \$1000 allotted by the Society for that purpose.

While there are national discords,—and I am sorry to have played on the black keys in reporting them,—yet there is harmony in New Jersey. We are marching along together. Everything is not perfect; but we are on our way, and our journey is not delayed by bickering and misunderstanding.

STATE SOCIETY ACTIVITIES

MEDICAL PRACTICE OF THE FUTURE

By HAVEN EMERSON, M.D.

Professor of Public Health, College of Physicians and Surgeons, New York City

An address before the Welfare Committee of The Medical Society of New Jersey, on February 19, 1939,
in the Stacy-Trent Hotel, Trenton, N. J.

I came across an expression of the attitude of many people in a bi-weekly Journal of the School of Journalism of Columbia University. It is an article by Dr. Kenneth M. Lewis, of New York, on "A Doctor's Viewpoint". One or two paragraphs I shall quote as an introduction to my remarks:

"A great deal is heard today about socialized medicine; and I am sure that most lay people and many physicians are quite confused by what is meant, and are quite uncertain about its potential implications. Strangely enough, the whole question seems to have come to the fore and to have been stressed as a problem that needed immediate solution, during the past few years.

"One would think to listen to the pros and cons, that medical care in the United States was at a low ebb and that some solution must immediately be found, unless we all were to suffer from a devastating calamity.

"Nothing, as a matter of fact, could be farther from the truth. Health conditions in the United States as compared to those in nations operating under some form of socialized medicine show that our system of medical care, as practiced at present, is definitely better than in those countries referred to.

"Why, then, if such is the case, is there such a hue and cry for changing our whole system of medical practice? To answer that question one must, I think, realize that there has been a definite effort during the past six years to change our national psychology. From a viewpoint of saving as

we go, paying for what we get, and each individual endeavoring to help himself, we have been taught more and more to rely upon government bounty, with the idea of getting something for nothing; with the result that more and more power has been centralized in the Federal Government. The farmer is regulated and told what he can grow and not grow; the businessman is regulated and told how he must run his affairs; the broker and the banker are hedged around with restrictions; and now it is the turn of the doctor. What do we mean by socialized medicine? Reduced to its simplest terms, it means the centralization and control of all medical practice in the hands of the government."

This item of news information chosen by the School of Journalism of Columbia University will make you realize how many people are thinking over this question. People are beginning to question; doctors are doubting themselves; and the public has been told to doubt doctors and to forget about paying bills. A saying on Long Island is, "What don't cost nuthin' ain't wuth nuthin'."

FEDERAL EXECUTIVE ORDER NO. 7481

The terms of the Executive Order that brought the matter to general public attention are interesting. On October 27, 1936, Executive Order No. 7481 was issued by the President of the United States in which the Social Security Board was directed "to continue to

sponsor coöperation among health and welfare agencies of the Federal Government; to continue to work under agreements then in effect; and to study and make recommendations concerning specific aspects of health and welfare activities of the (presumably federal) government looking toward more nearly complete coördination in these fields". We have now four documents as the result of that Executive Order:

1. National Health Survey (Jour., Feb., 1936, pp. 97 and 108); 2, Report of the Technical Committee on Medical Care (Jour., Aug., 1938, p. 503); 3, Report of the National Health Conference (Jour., Sep., 1938, p. 558); 4, the so-called Wagner Bill for National Health. I challenge you to find in any of these anything that is reasonably responsive to the Executive Order of the President in 1936. Whatever he meant to have done about it is not clear, but the Social Security Board received orders to continue to sponsor coöperation of health and welfare agencies of the Federal Government; to continue to work under agreements then in effect; and to study and make recommendations concerning specific aspects of health and welfare activities of the Federal Government looking toward its more nearly complete coördination in these fields.

It seems to me it would be very well to ask some of the federal representatives whether the Social Security Board and other federal agencies have done what is specifically called for in this Executive Order.

The national health program, which appears to me to be based on inadequate evidence and deductions, is a project for federal spending in order to hurry the distribution of wealth by supplying the backward and impoverished states with the same quality of medical care that is generally available in the wealthier and more populated states.

I wish to call attention to the report of the National Health Survey. No one would apply the term *health survey* to a searching for disease and disability. The proponents of the "national health program" hunted for disease and found it; more is found among the poor than among the well-to-do. What appears not to have been asked is, "Why is a sick person without medical care?" The investigators did not take the pains to distinguish between those not having care because they did not know how to get it, and those who wanted other kind of care than that of physicians (quack, cult or religious). It is curious that the percentage of population not having care as expressed by the

results of the survey is about the same as that found in the survey conducted by Bradley, of Philadelphia, who noted that about one-third of the people whom he questioned did not have medical care because they preferred to diagnose and treat their ills themselves. One-third of the population of any large city will be found to be outside the usual relationship between patient and physician.

The inadequate evidence which was called the health survey reveals nothing new as to the amount of sickness. It adds to our information of the different characters and distribution of sickness but gives no reason why 30 per cent of the population is not getting care. Is it because of unwillingness of the doctors to give service to the sick poor? or unawareness, on the part of the sick, of how to get it? or selfishness of doctors, or what? We have no analysis of facts which are given in this so-called national health survey; reasons for lack of medical attention are indispensable for arriving at an opinion as to what should be done.

The Technical Committee's Report is devoted largely to emphasizing inadequacies. Among the recommendations was a large program of hospital construction, particularly for mental diseases. Apparently about 4,000 psychiatrists will be needed to give the necessary medical care in these additional mental hospitals—and there is no means by which such a number of specialists can be prepared according to the present standards of education, nor the time to build up this expert psychiatric personnel to give the kind of service needed for this enlarged program of mental hospitals.

The Technical Committee proposes an increase in public health expenditures, public care of indigent sick, hospitals, and indemnity insurance, and compulsory sickness insurance. The A. M. A., American Hospital Association, American Public Health Association, and American Dental Association have passed resolutions with reservations in various respects—disapproving of health insurance and approving of expanded public health. One of the most significant resolutions was that of the American Hospital Association which approved of a plan of increased hospital facilities in the United States, but recommended that no undertaking for hospital building be sponsored by the Federal Government until a detailed study of local conditions disclosed what was needed and wanted by that particular community, and whether that community was prepared to staff and maintain such a hospital if it were built. The American Dental Association resolutions

suggest certain reservations, but it did not feel competent to express an opinion on certain aspects of the proposed program.

NEW JERSEY'S OPPORTUNITY

What are the states doing? and what specifically should New Jersey do? If federal money is spent it will be spent and distributed through State Health Officers. That seems to be perfectly clear and wise. No other representative of the state government can or should be the agent for preventive care. Whether the head of the health department is fully qualified or not, he will be the person with whom the Federal Government will deal in seeing how and where federal money is spent. Where we have trusted health officers they will apply the money intelligently as they would their own personal money.

This system is as good as can be created for this particular purpose, whether this money is for health, in which field the health officer is competent, or for medical care of the sick, for which he is rarely competent.

The State is expected to express the information on which needs are based and methods for meeting them. That is quite clear in all federal statements.

The elements involved appear to be:

- a. State Health Department.
- b. State Medical Society.
- c. State Department of Institutions and Agencies.

New Jersey is very fortunate in having Mr. Ellis in charge of its Department of Institutions and Agencies.

These three groups should meet with such representatives of the general public as may be suitable, and make a report to the public on the needs for care of indigent and low-income groups in sickness and for public health in the State. This report should include at least the following:

1. The specific needs of the State in public health.
2. The extent to which provision is made for the indigent and the medically indigent.
3. The care of low-income groups by voluntary prepayment plans, formulated by medical profession and under its direct or indirect control.
4. Extension of hospital services to include bed-care in the hospital and out-patient ser-

vices, visiting nurse service, and possibly home medical care.

5. The adequacy of hospital facilities.

RESPONSIVENESS TO LOCAL NEEDS

It is essential to retain the individual practice of medicine; and the general public should pay for much of the service to the poor out of tax money. I agree with the liberal and wise attitude of Dr. S. S. Goldwater, who feels we would lose much in just dumping the cost of all charity services upon the taxpayer. Charity cannot carry as much as it used to, but voluntary hospitals are the core of our medical resources for the sick poor. There is no other country which has anything comparable to our general voluntary hospitals. We expect that government, preferably local government, will pay for free care of the sick poor in part; but to say that all must be paid by the government would be going too far. I am not prepared to say that the medical profession can or should assume the full responsibility for non-paying patients, but the doctors will always do a large amount of this work free because it is their professional obligation. It is important to retain the individual practice of medicine; important that there should be payment of the medical profession for a good deal of medical care; but all doctors' and hospitals' bills of the indigent and near indigent cannot be paid by the local government. The public only begins to understand what the doctors are contributing. Local government cannot take over the entire cost of free medical care, and doctors should not try to force this issue. It is desirable to have the maximum contribution to cost of sickness by the locality, and minimum control by the government. The closer the responsibility of the local community, the better will the service be adapted to the needs of the community. There are many localities too poor to carry the minimum cost of care of the sick and of health. The State will have to aid its impoverished communities. The Federal Government must assist impoverished states.

The quality, results, and economy in any plan of public health or care of the sick depends on organized professional responsibility and complete community understanding and coöperation. The only way to do this is to have the physicians of the community, the county, or the state assume all professional responsibility for services, and the community to understand and accept responsibility for the costs, rather than passing the duty of plan and performance over to government officials

whether in Federal or State Departments of Health.

Any plan for better national health must be built upon existing local and state resources, both official and voluntary, the financial assistance of which by federal grants may be justifi-

fied and necessary in some particular instances and in certain fields of health promotion and care of the sick in backward states suffering from economic and other disadvantages.

630 West 168th Street

REPORT OF THE COMMITTEE ON VOLUNTARY HEALTH INSURANCE

Made to the Welfare Committee, February 19, 1939

In October, 1938, President Carrington appointed Dr. Read Chairman, with Drs. Lewis, Hawkes, McBride, Snedecor, Wilkes, and Sprague, associates, to be a special committee to study cash indemnity insurance for medical costs. This committee completed its work in December, 1938, and reported its findings as follows (Jour., Feb., 1939, p. 103):

"1. We believe that some form of voluntary cash indemnity insurance for medical costs is practical, either through old line insurance companies, or a non-profit company to be organized along the lines of the hospitalization insurance plan with the endorsement of the State Society, or by the State Society itself.

"2. We have recommended the preparation and distribution of a comprehensive brochure to the individual members of the State Medical Society, giving them at some length the results of our studies.

"3. We have recommended that, if individual members, by an actual poll, show an interest and willingness to coöperate, the plan be tried out in one, or possibly two counties of this State."

In January, 1939, President Carrington appointed Drs. German, Lance, Rucker, Todd, and Sprague to be a committee to carry on investigations into this involved problem, and to determine, if possible, the advisability and feasibility of the development of a *medical expense indemnity plan* for the State of New Jersey. If the institution of such a plan seems to be advisable, then this committee is to broadly outline the plan, and state the facts and conditions pertaining thereto.

GENERAL CONSIDERATIONS

The medical profession realizes that it occupies a position of trust in society, and that it is under a duty to provide the best medical care for all the people.

From time immemorial physicians throughout the world have cared for the poor with

little or no remuneration. It is a well-known fact that the medical needs of the poor have been supplied by physicians more readily than their other physical needs, such as shelter, clothing and food, have been provided for by the State. Scientific medical practice occupies an advanced position today because it makes prompt application of its scientific discoveries to all forms of medical practice. This satisfactory state of medical practice is one of the results of freedom in the relationships of the physician to his patient; and whatever medical service plan any committee may recommend must be based on preserving all the principles on which good medical practice has been founded.

This Committee on Voluntary Health Insurance has approached this problem with very meager records of actual experience as a guide. Therefore, progress will need to be on an experimental basis, preferably of one-year periods.

LEGAL

Before any plan can be instituted, certain *legal* conditions must be met. After a conference with the Banking and Insurance Commission of New Jersey, it was evident that The Medical Society of New Jersey should not institute a *Medical Expense Insurance Plan* under its own name, or within its official body. On the other hand, the Medical Society may sponsor such a plan. The Society may appoint a group of physicians and laymen to act as a State Board of Trustees in carrying on the plan. The project would require incorporation under its own name,—such, for example, as *The Medical Service Plan of New Jersey*.

LEGISLATION

Before the plan can operate, it must have suitable enabling legislation. This would require the development of a satisfactory bill

after conference of our officers with the State Banking and Insurance Commission, and with legal counsel. Such a bill would then have to be passed by the Legislature of New Jersey, and signed by the Governor.

Before proper legislation can be initiated, we must have a concrete and definite policy prepared so that it can be submitted to the Banking and Insurance Commission and the Legislature.

The proposal is to develop a system for *independent self-help*. The plan is to be an effort to assist the low-income group to meet their catastrophic medical expenses by means of the insurance principle of the distribution of the costs over the community for a long period of time. Such a plan should preserve the good features of private practice, particularly its individualism, its competition, its efficiency, and its rewards.

The problems which confront the committee are numerous, for a perfect plan cannot be brought into being at once. Progress will need to be slow and based on our own experience, or else serious grief will follow.

FUNDAMENTAL PRINCIPLES

The committee believes any plan must include certain fundamental principles, as follows:

1. The plan is to be on a non-profit basis, with community interest.

2. All licensed physicians in the State are eligible to participate in the plan. Limited licensees are not eligible.

3. Free choice of physician, and free choice of patient, are to be preserved.

4. Administrative control of the plan, direct or indirect, and the policy to be recognized, are to be vested in The Medical Society of New Jersey through its power of appointment to the State Board of Trustees of the plan. Administrative expenses must be kept low, as near 10 per cent as possible and not to exceed 15 per cent. Lay assistance and advice are to be developed through representative membership on the Board of Trustees, but voting control should be in the hands of physicians.

5. The State is to be divided into county units; and the State Board of Trustees is to establish the *master plan*. Each county unit is to operate under the plan. The State Board of Trustees acts in an advisory capacity. The local county committees are to have sub-committees for definite duties. Local county committees are to have disciplinary powers. Appeal from the local committee may be made to the State Board of Trustees. Physicians may be dropped from the benefits for cause.

6. The scope of the medical service may be limited in certain conditions. These are to be determined at a later date, and the service may wholly exclude certain conditions arising in operation of the Workmen's Compensation Act, or where someone is responsible for the bill, or under other special circumstances of chronic diseases, et cetera, to be determined later.

7. The contract is to be simple and explicit, and definitely state that the limit of payment to one individual in any one year shall not exceed three hundred dollars.

8. No membership fees or registration fees shall be required of the physician.

9. Fee schedules are not to be developed at the onset. If a dispute arises, that problem will be met from experience.

10. Applications are to require information as to past illness; and a statement of present health and full reports of the present illness are to be obtained from the patient, the physician, and the hospital records.

11. Top limits of income eligibility must be established, above which level of income the individual is not eligible for the plan. Such level is to be based on the relationship of the family status.

12. The policy must apply to the individual wherever he may be taken ill.

13. Payments are to be limited to house- or hospital-confining or otherwise disabling illness. The first two days of such illness are to be excluded.

14. Benefits are to be limited to wage earners only at onset.

15. The plan includes payroll groups only at the start, on the schedule used in the Hospital Service Plan.

16. Payments are to be made on a proportional fee or unit basis from a pooled fund.

17. If the proposed plan is acted upon favorably by the Board of Directors and Officers of The Medical Society of New Jersey, it is to be presented to the physicians of the State by letter, or by exhibition of the plan in the State Medical Journal before final action is taken by the House of Delegates.

To complete and set up a definite and final plan requires further intensive study and work. This committee recommends for this purpose:

- A. That a *Founding Committee* be appointed by the President and the Trustees; such committee to be large enough to adequately represent the State.

- B. Such committee to be empowered to expend money for the gathering of necessary data, and the employment of needed help and legal counsel.

C. When the Founding Committee has completed the development of the contemplated plan and the policy, the same are to be submitted to the Trustees for their consideration and action.

The present committee is of the opinion that the threatened danger of regimentation of our profession is not as imminent as it appeared six months ago. Therefore, we believe we have sufficient time to carefully consider and develop a sound Medical Service Plan.

Inasmuch as the work of this committee has been finished, the existence of this committee as such should come to an end. Therefore, we beg to be discharged.

EDWARD W. SPRAGUE,
Chairman
ELTON W. LANCE
GEORGE B. GERMAN
WILLIAM H. TODD
WILLIAM C. RUCKER

WELFARE COMMITTEE

A regular meeting of the Welfare Committee was held on February 19, 1939, at 2 p. m., in the Stacy-Trent Hotel, Trenton, N. J. It was preceded by regular meetings of fifteen advisory committees that had been scheduled in each issue of The Journal, on advertising pages IV-VII. The committees which met were those on:

Adult Health
Auxiliary Medical Services
Cancer Control
Child Health
Constitution and By-Laws
Contract Practice
Industrial Injuries
Medical Care of the Indigent
Nursing and Nursing Education
Pharmaceutical Problems
Pneumonia
Sterilization
Traffic Accidents
Tuberculosis
Venereal Diseases

At 12:45 o'clock a luncheon was served to the members of the Advisory Committees and the Welfare Committee. Immediately after the luncheon a meeting of the Welfare Committee was held with the Chairman, Hilton S. Read, presiding, and the following members present:

Atlantic—

Hilton S. Read, Chairman
William J. Carrington, Ex-Officio
Robert A. Kilduffe

Bergen—

G. Barton Barlow Charles Littwin

Camden—

Ernest G. Hummel R. L. Sharp

Cape May—Harry B. Walker

Cumberland—

Millard F. Sewall Leslie E. Myatt

Essex—

Arthur W. Bingham I. Irving Fort
Edgar P. Cardwell Julius Levy
Harry N. Comando A. Charles Zehnder

Gloucester—Chester I. Ulmer

Hudson—

A. E. Jaffin B. S. Pollak
William W. Maver Joseph F. Londrigan
James F. Norton

Middlesex—

George W. Fithian Joseph H. Kler

Monmouth—

C. Byron Blaisdell William G. Herrman

Morris—George J. Young

Ocean—Eugene G. Herbener

Passaic—

Sigurd W. Johnsen Frank Ash
Wright MacMillan

Salem—David W. Green

Somerset—Frank L. Field

Union—Norman W. Burritt

Warren—William H. Varney

Advisory—

William H. MacDonald
Robert P. Fischelis
Frederic J. Quigley
LeRoy A. Wilkes, Secretary
Frank Overton, Editor
Norman M. Scott, Executive Assistant

ADDRESS BY DR. HAVEN EMERSON

Dr. Haven Emerson, Professor of Public Health in the College of Physicians and Surgeons, New York City, was the guest speaker, taking for his subject "Medical Practice of the Future". The address was an analysis of the illogical attitude of the Federal Government toward the present methods of practice. An abstract of the address is printed on page 162 of this Journal.

NORTHWEST REGIONAL CONFERENCE

President William J. Carrington gave a report of the Northwest Regional Conference which he attended on February 12, 1939, in Chicago. This report is printed on the President's Page of this Journal (page 159).

REPORT OF THE SPECIAL COMMITTEE ON
VOLUNTARY HEALTH INSURANCE

Dr. Edward W. Sprague, Chairman of a special committee to formulate the broad principles on which a system of voluntary cash indemnity insurance for medical costs can be established in accordance with the report of Dr. Hilton S. Read (Jour., Feb., 1939, p. 103). Dr. Sprague's report is printed on page 165 of this Journal.

PUBLIC RELATIONS COMMITTEE

Dr. J. H. Kler, Chairman of the Committee on Public Relations, gave the following report on the subject "Paid Medical Advertising":

At the last regular meeting of the Committee on Public Relations of The Medical Society of New Jersey held at Trenton, December 4, 1938, the advisability and desirability of a paid advertising program for the medical profession of New Jersey were carefully considered.

The committee approved paid institutional advertising in newspapers in order to acquaint the public with the ideals, policies, program, and work of the county medical societies in New Jersey. The members of the Committee on Public Relations believe the question of paid advertising should be decided by each county medical society.

The Committee on Public Relations is

equipped to prepare the actual advertising matter for county medical societies if requested. The advisory services of experienced newspapermen and advertising workers are available to county societies without cost.

The Committee on Public Relations of The Medical Society of New Jersey respectfully urges that this question be placed on the agenda of your county medical society.

On motion, the report was accepted.

LEGISLATION

Dr. B. S. Pollak, Chairman of the Committee on Legislation, reviewed the progress of Assembly Bill 210, which is a modification of last year's A-511.

MATERNAL WELFARE

Dr. A. W. Bingham moved that the showing of the film "The Birth of a Baby" to lay audiences under the restrictions of the National Maternal Welfare Committee, Inc., be approved. This motion was adopted unanimously.

Dr. Bingham also referred to the need of the adoption of more definite procedures for giving maternal care in outlying rural districts, and suggested a method of coöperation between the Family Doctor, the Field Physician, and the Public Health Nurse, under the direction of an executive committee composed of the Field Physician, two appointed members of the county medical society, and a representative of the nursing group. This suggestion was unanimously adopted.

The Welfare Committee adjourned at four o'clock.

LEROY A. WILKES, *Secretary*.

ANALYSIS OF THE UNIFORM MEDICAL PRACTICE ACT

1. We ask for full *citizenship* as a requirement of those who want to practice medicine or to take the examination of the Board of Medical Examiners. This was approved two years ago by the House of Delegates.

2. We set up a *standard of educational requirements*, which in substance means that the chiropractors cannot be licensed to practice after 1940, unless they have the equivalent medical and professional qualifications required of all M.D.'s, and of those Doctors of Osteopathy who qualify as legal practitioners of medicine and surgery.

N. B.—The present limited licensees are unaffected by this law.

3. We set up *definite additional reasons for the revocation of license*. Everyone knows that this provision is now very weak. Under the

present set-up an insane doctor can practice medicine.

4. We have provided penalties for those who violate the medical practice act,—*real penalties*. At the present time the penalties are too weak. For each offense the offenders only pay a fine. In this bill there is a fine of \$200, or a jail sentence, for the first offense; for the second offense \$500, or a jail sentence; for subsequent offenses the Attorney General or the State Board of Medical Examiners can go before the Chancery Court to get a restraining order to prevent the offender from practicing medicine in this State.

This bill is supported by The Medical Society of New Jersey, the New Jersey Osteopathic Society and its component county societies, the New Jersey Public Health Nurses'

Association, the New Jersey Health Officers' Association, the New Jersey Pharmaceutical Association, the New Jersey Tuberculosis Association, the New Jersey Manufacturers' Association, the Prudential Life Insurance Com-

pany, and many insurance companies and individuals interested in public health work.

B. S. POLLAK, M.D., *Chairman*,
Sub-Committee on Legislation of
the Welfare Committee.

LEGISLATIVE BULLETIN NUMBER TWO

The *Uniform Medical Practice Act* was introduced into the Assembly February 20. The identifying number is A-120. The bill is now in the Judiciary Committee of the Assembly. The committee members are:

Mr. Roscoe P. McClave, Cliffside Park (Bergen County)
Mr. John M. Kerner, 125 Broad Street, Elizabeth (Union)
Mr. Frank S. Platts, 124 Montrose Street, Newark (Essex)
Mr. J. Stanley Herbert, 601 Bangs Avenue, Asbury Park (Monmouth)
Mr. Fred W. DeVoe, Lawyers' Building, New Brunswick (Middlesex)

Assemblyman McClave, who is sponsoring the bill, is the majority leader of the Assembly and Chairman of the Judiciary Committee. He is both interested and influential, and will do his full share, which obligates each member of The Medical Society of New Jersey to convince the members of the Legislature in his county that the Society is *united and persistent in support of this bill*.

If each County Society, through its members, will show its support of this legislation by personal contacts (best), personal letters (next best) or telegrams, and will repeat this evidence of support as often as necessary, the outlook for the passage of the bill in both houses is bright. It is primarily the *support in each county* which will decide the issue. Governor Moore will, in all probability, sign the bill if we may judge from his liberal support of medical legislation in the past.

The following bills have been introduced since you received Legislative Bulletin number one (Jour., Feb., p. 119). The two most important bills among those listed below are the chiropody bill, which must be vigorously opposed because of the attempt of the chiropodist to expand, without additional preparation, into the field of orthopedic surgery with the same

qualifications established at the time his license was issued as a chiropodist. The other bill is our own A-210 mentioned above, for which we urge unanimous support.

SENATE BILLS

S-92—Bowers—Feb. 6—To provide tuberculosis tests for school children. Feb. 6—Committee on Education.

S-94—Bowers—Feb. 6—Companion bill to S-92. To provide for a more thorough above-the-waist examination of school pupils. Feb. 6—Committee on Education.

S-93—Bowers—Feb. 6—To authorize boards of education to require physical examinations of all employees at least once in three years, and also examinations of employees evidencing ill health. Feb. 6—Committee on Education.

S-144—Bowers—Feb. 20—To permit board of education to require vaccination for diphtheria. Feb. 20—Public Health Committee.

ASSEMBLY BILLS

A-62—Wegrocki—Jan. 23—To fix the qualifications of persons eligible to take examinations for license to practice medicine and surgery. *To be vigorously opposed*. Jan. 23—Public Health Committee (Hargrave, Stokes, Wegrocki, Worrell, Browne).

A-199—Wegrocki—Feb. 13—To regulate the practice of chiropody. Feb. 13—Committee on Public Health. *To be opposed*.

A-200—Wickham—Feb. 13—To provide for the incarceration of drug addicts by Common Pleas Judges upon complaint and after a hearing. Feb. 13—Committee on Public Health.

A-210—McClave—Feb. 20—UNIFORM MEDICAL PRACTICE ACT. (N. B. Revision of former "A-511".) Feb. 20—Judiciary Committee.

A-226—McClave—Feb. 20—To provide for the position of chief medical examiner at the option of the Board of Freeholders in second-class counties. It makes records of sudden and violent deaths public records. Feb. 20—Judiciary Committee.

A-245—Palese—Feb. 20—Makes numerous amendments to the act regulating foods, drugs, cosmetics, appliances and devices intended for use in the treatment of human ailments, to bring State regulation more in conformance with Federal regulations. Feb. 20—Judiciary Committee.

LEGISLATIVE BATTLES ARE WON OR LOST BACK HOME

Keep your Senator and Assemblymen informed as to the attitude of The Medical Profession in New Jersey.

Please save all Legislative Bulletins for future use.

CRIMES OF SEX PERVERSION

A COMMITTEE REPORT

The following is the report of the special reference committee appointed by The Medical Society of New Jersey to study and recommend suitable disposition of the set of resolutions formulated by the Grand Jury of Union County concerning the proper handling of the increasing number of sex perversion cases appearing in the courts of this State.

The said resolutions suggest the erection of special institutions within the State for curative treatment of these cases, the same to be divided into male and female; and adult and juvenile.

It was further recommended that boards of psychiatrists, consisting of not less than three qualified physicians, be created in each county for the purpose of advising the judges as to the correct disposition of each case. These boards are to be appointed by the Justice of the Supreme Court and the Judge of the Common Pleas Court sitting in the particular county.

THE FINDINGS

Facts agreed upon by your committee are as follows:

1. Adult cases in general are incurable.
2. Minor forms of perversion among the sane are carried on by choice, or as the result of habits established in youth. Such cases, if so desiring, can be cured by a minimum of professional advice or by individual initiative.
3. Only when the form of perversion practiced affects other members of society does the legal aspect enter the case. Such cases, in the adult, are mostly incurable and warrant separation from society.
4. The major offenses are based either upon insanity, and are remediable only to such extent as is the underlying mental derangement; or upon an abnormal sex urge which, when aroused, is uncontrollable by anything short of physical restraint.
5. Juveniles may be divided sharply into two classes: 1, Those who are unsound mentally; and 2, those who, fundamentally sane, have acquired bad habits as a result of faulty training, contact with adult habitues, or by reading obscene literature. (It should be noted here that, in the more or less hysterical crusade against syphilis, literature has appeared which actually condones the abnormal gratification of sex desire as the lesser of two evils.)
6. The cure in all cases, with the exception

of those suffering from permanent mental disease, is in preventive measures.

PREVENTIVE MEASURES

Inasmuch as the proper handling of this problem lies largely in prevention, the following are some of the steps suggested:

1. Enlarged *playground* facilities, with well-organized sports, will play an important part in the solution of this problem; and in addition, it should be the effort to provide *extra-curricular activities* for all students in junior and senior high schools.

2. Training of parents in the proper method of approaching their children on the sex problem.

3. Careful study of juvenile delinquency in our schools, with particular attention to any possible sex phase.

4. Early separation of mental defectives from the normal children.

5. Coöperation of school authorities with mental hygiene clinics in all problem cases.

6. Carefully prepared courses or lectures on sex in our high schools, given by well-chosen physicians.

7. More rigid suppression of obscene literature. (In this connection it should be called to mind that the present-day trend to minutely detailed brutal frankness in some of the outstanding literary productions gives rise to a very nice problem as to what books should be advised as suitable for the high school student.)

At the present time, with an increasing burden of State debt, it would hardly seem justifiable to approve the erection of new institutions, particularly in view of the above-stated facts.

Criminal cases among the juveniles might well be cared for in special wards, or buildings attached to houses of correction.

A medical adviser or an advisory board of psychiatrists would unquestionably be of great value to the Judge, provided the appointee or appointees be selected from names suggested by the County Medical Society and that professional fitness exclude completely political patronage. It is doubtful whether a board of three will be essential in most of the counties in New Jersey.

February 19, 1939.

THOMAS K. LEWIS, M.D.
WATSON B. MORRIS, M.D.

RABIES IN NEW JERSEY

A COMMUNICATION FROM THE STATE DEPARTMENT OF HEALTH

At a meeting of the State Health Department held on February 14, careful consideration was given to the rabies situation in this State, and the serious spread of this disease, as indicated by case reports. Records in the office of the State Health Department show that during the calendar year 1938, there were reported to the Department some 537 cases of rabies in animals. Records further show that in January, 1939, 100 cases were reported; while only five cases were reported in January, 1938. The reports received during February indicate that the rate of prevalence of this disease during February is at about the same level as in January.

The recent cases occurred chiefly in the Counties of Bergen, Essex, Passaic, Union, Somerset, and the northern part of Middlesex.

Prior to the meeting of the State Department of Health on February 14, the Joint Rabies Committee, consisting of representatives of the State Medical Society of New Jersey, the New Jersey Health Officers' Association, the New Jersey Health and Sanitary Association, the New Jersey Veterinarians' Association, and the State Health Department, together with a group of invited persons, had considered the rabies situation, and recommended that local boards of health in several of the northeastern counties serve notice on owners of dogs to confine their animals, as authorized under the present rabies law. This group further recommended that the State Health Department order the local boards of health in a number of the counties affected to serve notices on all dog owners.

At the meeting of the Department a resolution was adopted to the effect that the local boards of health in Bergen, Passaic, Essex, Union, Somerset, and the northern part of Middlesex County be ordered to serve notice on all dog owners within their respective municipalities to confine their dogs for a period of

three months, or until a certificate of release had been issued by the local health board. Such an order has been issued to the boards of health concerned.

The State Health Department feels that the word "Confine" should mean that the dog shall be kept in a pen, enclosure, or building, except when on leash accompanied by a responsible person.

The Department expresses its opinion that a properly regulated dog show does not increase the likelihood of the spread of rabies: but it suggests that, when such a show is contemplated, the local board of health first make inquiry as to measures which will be taken at the show to prevent contacts between animals.

It further suggests that, if the owner of a dog in an affected territory wishes to enter his animal in a dog show, the State Health Department would have no objection, provided that the local board of health issues a temporary certificate of release after being reasonably satisfied the animal had not been exposed to rabies.

During the year 1938 two fatal cases of rabies in humans were recorded in New Jersey; and in January, 1939, a third human death from rabies was recorded.

The State Health Department is not urging the mass or compulsory inoculation of dogs against rabies with the method and material now available.

Editorial Note—The following report concerning the dog population of the City of Trenton, N. J., is taken from the *Trenton Evening Times* of February 23, 1939:

Number of dog license tags issued in 1938.	6041
Number of persons reported as bitten by dogs in 1938	328

These figures vary less than ten per cent from those of the years 1937 and 1936.

ASSOCIATION OF MILITARY SURGEONS

A meeting of the New Jersey Chapter of the Association of Military Surgeons of the United States was held in Newark on the evening of February 23rd under the direction of the President, Lt. Col. Albert G. Hulett, Med. Res., U. S. Army, East Orange, and the Secretary, Capt. Edward A. Wickham, San. Res., U. S. Army, Newark. About twenty-five members were present at a social supper held in

the Hotel Douglas at 7 o'clock, after which the regular meeting was held in the Academy of Medicine, with a larger audience.

President Hulett made a brief report of the activities of the Association.

The principal address was given by Lt. Commander Henry H. Kessler, Medical Corps, United States Naval Reserves, on the subject of artificial arms and hands under the patient's

voluntary control by the use of the muscles which still remain in the upper part of the limb. A canal is made through the muscle and lined with skin grafts; and through it an ivory pin about the size of a lead pencil is thrust. Strings from these pins lead to the artificial fingers, or other part to be moved. By means of a pin on the flexor side of the limb, and another on the extensor side, the movements of the fingers of the artificial hand are controlled.

Dr. Kessler showed moving pictures of patients with artificial hands and arms doing the work of a normal man in a machine shop. Two patients who had lost their forearms were present and demonstrated their ability to use their new hands normally.

The next Chapter meeting will be held in the Paterson area during June. Information may be obtained from the local chairman, Lt. Com. H. G. Walker, Wyckoff, N. J.

OBITUARIES

DR. A. F. W. SFERRA

Dr. Alfred Frederick William Sferra, of Bound Brook, aged forty-five years, died suddenly on New Year's Day, 1939, while giving a party to a few close friends.

Dr. Sferra was born in Italy, but was reared in Bound Brook. He graduated from Rutgers University in 1915, and accepted a position with the Monsanto Chemical Company, St. Louis, Missouri. He held the position for ten years, and had married and had four children when he began the study of medicine in St. Louis University, working with the chemical company nights to support his family.

Dr. Sferra graduated in 1929, and served an internship in Muhlenberg Hospital, Plainfield, and began private practice in Bound Brook. He was successful in his private practice, and public-spirited in his civic associations. He was President of the Somerset County Medical Society, County Coroner, Borough Physician, and a member of the medical staffs of St. Peter's Hospital in New Brunswick, Somerset Hospital in Somerville, and Muhlenberg Hospital, Plainfield. He was a member of the

Knights of Columbus, and the Elks, and of several Italian organizations.

MEMORIAL TO DR. SFERRA

The following memorial was adopted by the Somerset County Medical Society at its meeting on February ninth:

We, the fellow-members with Dr. Alfred F. W. Sferra, in the Somerset County Medical Society, desire to express our appreciation of the services of Dr. Sferra to this Society, in which he had toiled long and well for the benefit of the general public. For years he ably performed the duties of Secretary of our Society, and later served as its President with honor and distinction. As a kind and skillful physician, he was adored by his patients, and loved by his fellow-doctors.

A. A. LAWTON,
G. E. BARBOUR,
R. F. HEGEMAN,
Committee.

JULES BAECHLER, M.D.

Dr. Jules Baechler, of 439 Sixteenth Street, West New York, N. J., died from cerebral hemorrhage on February 11th, 1939, at North Hudson Hospital.

Dr. Baechler was born in Geneva, Switzerland, in 1877, and had been in this country fifty-eight years. He attended the public schools of New York City, and received his medical degree from the College of Physicians and Surgeons in 1907. He interned at the French Hospital, New York, for a year; and after several years' practice in New York he moved to West New York. Dr. Baechler was the Founder of the Baby Welfare Station in

West New York, and also served the public schools for twelve years as Medical Examiner.

He was a member of Bluestone Lodge No. 213, F. and A. M., North Hudson Chapter, Royal Arch Masons, and Pilgrim Commandery, No. 16, Knights Templar. Also a member of the American Medical Association, The Medical Society of New Jersey, and the Hudson County Medical Society.

He is survived by his wife, Mrs. Margaret Baechler (nee Grandlienard), a son, J. Henry Baechler; a brother, Gustave Baechler, and a sister, Miss Josephine Baechler.

DR. FRANK W. CURTIS

Dr. Frank W. Curtis, a physician in Stewartsville for the last forty-five years, died on February 9th after a brief illness. He was born in Hackettstown April 9, 1865, and graduated from the Long Island College Hospital in 1892, and practiced medi-

cine in Stewartsville, Warren County, ever since.

Dr. Curtis was connected with the Easton Hospital, and was President of Weaver's Pharmacy in Easton. He was active in Masonry, and in the Presbyterian Church at Stewartsville.

DR. MARSHALL F. LUMMIS

Dr. Marshall F. Lummis, of Pitman, aged sixty years, died on February 25, 1939, in the Hahnemann Hospital, Philadelphia, from a general staphylococcal infection of only three days' duration.

Dr. Lummis was a native of Cumberland County, and attended the South Jersey Institute in Bridgeton. He had practiced in Pitman since 1903, when he received his medical degree from the University

of Pennsylvania. During the World War he was in active service in France.

Dr. Lummis was one of the founders of the Kiwanis Club of Pitman. He was President of the Gloucester County Medical Society in 1937. An excellent likeness of him appears in the center of the group picture of the Society which was reproduced in The Journal of May, 1937, p. 356.

DR. ALFRED E. OAKES

Dr. Alfred E. Oakes, of Elizabeth, died of acute heart attack on December 20th, 1938, at the Alexian Brothers Hospital, Elizabeth, at the age of fifty-two. After graduating and practicing as a pharmacist, Dr. Oakes received his medical education at

Bellevue. He saw service in France with different medical units, and resumed practice in Elizabeth after peace was declared. His sudden death came as a great shock to his many friends.

LIST OF PHYSICIANS DYING IN NEW JERSEY, JANUARY, 1939

From the records of the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
E. A. Carpenter	56	Jan. 1	Paterson	Passaic	Burns. Broncho pneumonia.
William F. Finney	90	Jan. 18	Trenton	Trenton	Prostatitis. Broncho pneumonia.
Percy M. Foshay	71	Jan. 26	Glen Ridge	Montclair	Coronary sclerosis.
Abraham Mintz	34	Jan. 28	Newark	Newark	Chronic leukemia.
William O'Connor	73	Jan. 30	Paterson	Same	Cerebral hemorrhage.
William H. Pullen	72	Jan. 31	Leonia	Greenwich, Conn.	Carcinoma of prostate.
Joseph M. Rector	71	Jan. 10	Jersey City	Same	Carcinoma of stomach.
Alexander Ross	62	Jan. 1	Haddonfield	Same	Lobar pneumonia.
Alfred F. W. Sferra	45	Jan. 1	Bound Brook	Same	Coronary thrombosis.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE
STATE BIOLOGICALS SINCE JULY 1, 1938

DIPHTHERIA TOXOID

County	Total to Dec. 31	Month of Jan.	Total to Jan. 31	Average per Month
Atlantic	487	125	612	87.4
Bergen	1760	425	2185	312.1
Burlington	81	170	251	35.8
Camden	658	498	1156	165.1
Cape May	353	1	354	50.5
Cumberland	65	18	83	11.2
Essex	6508	890	7398	1056.8
Gloucester	50	20	70	10.
Hudson	1958	1070	3028	432.5
Hunterdon	4	1	5	.7
Mercer	1346	77	1423	203.2
Middlesex	866	76	942	134.5
Monmouth	215	63	278	39.7
Morris	275	33	308	44.
Ocean	67	53	120	17.1
Passaic	1543	385	1928	275.4
Salem	62	130	192	27.4
Somerset	84	11	95	13.5
Sussex	0	5	5	.7
Union	867	179	1046	149.4
Warren	100	248	348	49.7
Total	17349	4478	21827	3118.1

SMALLPOX VACCINE

County	Total to Dec. 31	Month of Jan.	Total to Jan. 31	Average per Month
Atlantic	395	98	493	70.4
Bergen	1376	303	1679	239.8
Burlington	242	6	248	35.4
Camden	2128	55	2183	311.7
Cape May	332	4	336	48.
Cumberland	181	23	204	29.1
Essex	3230	267	3497	499.8
Gloucester	298	108	406	58.
Hudson	2486	175	2661	380.1
Hunterdon	17	0	17	2.4
Mercer	854	98	952	136.
Middlesex	1602	81	1683	240.4
Monmouth	991	15	1006	143.7
Morris	628	33	661	94.4
Ocean	45	0	45	6.4
Passaic	1255	155	1410	201.4
Salem	335	22	357	51.
Somerset	1110	35	1145	173.4
Sussex	0	0	0	0.
Union	775	131	906	129.4
Warren	148	4	152	21.7
Total	18428	1613	20041	2863.

CONTACTS AND COMMENTS

Turn to page 140 and read the editorial comment of the New York Herald-Tribune on the health bill introduced in Congress by Senator Wagner.

THE EXECUTIVE OFFICES OF THE MEDICAL SOCIETY OF NEW JERSEY



The process of folding, inserting in envelopes, and mailing 5000 bulletins requires the continuous services of three employees for two days.

Visit the Executive and Editorial offices, and see for yourself the varied activities that go on in that beehive of industry. See the records that are in process of compilation. Ask any question that you choose regarding any phase of the activities of The Medical Society of New Jersey, and of its relations to every county society, and see its visible record which contains the answer.

When the Executive Offices were established, the meager records which were turned over to it were loosely piled into one box. The records which have accumulated since that time fill rows of files, and also a room in a vault in the basement. An important feature of the records is an up-to-date card index of every physician in New Jersey.

A visit to the central office will reveal the variety and efficiency of its activities and the processes whose invisible results are crystallized in the current bulletins that are sent out, and in the public record in *The Journal*.

EXAMINATIONS

Examinations for the positions of medical internes in the institutions of California for treatment of the insane and the feeble-minded will be held under the auspices of the State Personnel Board, 1025 P Street, Sacramento, California. Since an official notice regarding the examinations was received in the Editorial Office, it is presumed that the examinations and positions are open to physicians from New Jersey.

ART EXHIBIT

The American Physicians' Art Association, composed of over seven hundred physicians throughout the country who have become proficient in all kinds of art work as an avocation, will conduct its second Art Exhibit at the City Art Museum of St. Louis, May 14-20, 1939, during the Convention of the American Medical Association.

Practically all forms of art work will be accepted including paintings, drawings, photographs, sculpture, ceramics, woodcarving, metal work, and book-binding. Over sixty prizes will be awarded.

For details of membership in this Association and rules of the Exhibit, kindly write to Max Thorek, M.D., Secretary, 850 Irving Park Boulevard, Chicago, Ill., or F. H. Redewill, M.D., President, 521-536 Flood Building, San Francisco, Cal.

LECTURES ON OBSTETRICS

A series of lectures on practical obstetrics will be given at the New York Academy of Medicine, 2 East 103rd Street, New York, on Wednesday afternoons at 4:30 o'clock, under the joint sponsorship of The New York Academy of Medicine and the Medical Society of the County of New York. The program is as follows:

March 1—The Use of Analgesics in Labor, Thaddeus L. Montgomery, Philadelphia.

March 8—Syphilis in Pregnancy, Joseph N. Nathanson.

March 15—Principles of Hormone Diagnosis and Theories of Endocrine Therapy in Pregnancy, Howard C. Taylor, Jr.

March 22—Management of Pregnancy Complicated by—

(a) Tuberculosis, J. Burns Amberson, Jr.

(b) Heart Disease, Edwin P. Maynard, Jr.

March 29—Recognition and Management of Abnormal Presentations, Albert H. Aldridge.

April 5—Sulfanilamide and Other Therapy in the Treatment of Post-abortion Sepsis, Post-partum Sepsis, and Pyelitis; Edward G. Waters, Jersey City.

Physicians from New Jersey, particularly those in the metropolitan areas, are cordially invited to attend these lectures.

MAHLON ASHFORD, M.D., *Medical Director*,
For the Committee on Medical Education.

PRIZE ESSAY

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons announces that the annual Foundation Prize for this year will be \$100.00. Those eligible include only (1) interns, residents, or graduate students in obstetrics, gyne-

cology and abdominal surgery, and (2) physicians (M.D. degree) who are actually practicing or teaching obstetrics, gynecology or abdominal surgery.

Competing manuscripts must (1) be presented in *triplicate* under a non-de-plume to the Secretary of the Association before June 1st, (2) be limited to 5,000 words and such illustrations as are necessary for a clear exposition of the thesis, and (3) be typewritten (double-spaced) on one side of the sheets, with ample margins.

For further details, address Dr. James R. Bloss, Secretary, 418 Eleventh Street, Huntington, West Virginia.

EXAMINATIONS—AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Application for admission to the Group A, May 1939, Board examinations must be on file in the Secretary's office not later than March 15, 1939.

The general oral, clinical and pathological examinations for all candidates, Part II examinations, will be held as follows: Group A, Saturday and Sunday, May 13 and 14; Group B, Monday and Tuesday, May 15 and 16, immediately prior to the annual meeting of the American Medical Association, at St. Louis, Missouri. Notice of time and place of these examinations will be forwarded to all candidates well in advance of the examination dates.

Candidates for reëxamination in Part II (Groups A and B), must request such reëxamination by writing the Secretary's Office before March 15, 1939. Candidates who are required to take reëxaminations must do so before the expiration of three years from the date of their first examination.

The annual dinner meeting of the Board, to which all diplomats and candidates are invited, as well as wives and others interested in the work of the Board, will be held on Wednesday evening, May 17, following the close of the examinations.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

PAUL TITUS, *Secretary*.

ANNOUNCEMENTS

The "Contacts and Comments" department of The Journal will carry announcements of coming meetings in which members of the Society may be interested. Among them will be announcements of courses of lectures in the New York Academy of Medicine, and the Philadelphia County Medical Society. Notices of meetings of such organizations as the New Jersey Society of Surgeons, and of the leading health and welfare organizations of New Jersey will be printed if they are received a fortnight before the meeting dates. Abstracts of the proceedings of the societies will also be printed if

they are sent in a concise, informative form, which includes something of the scope of the content of the addresses which have a medical appeal.

It is the desire of the Publication Committee to promote a spirit of friendly coöperation between the physicians of New Jersey and the workers in the welfare organizations.

LEGISLATION

Medical legislation will receive special attention during the session of the Legislature. Physicians who oppose some minor feature of a bill are likely to give the impression that physicians generally are not in favor of a bill which is actually heartily supported by 90 per cent of the doctors. If you do not like a minor feature of a bill, write your objections to the Executive Officer, rather than to a legislator.

MEDICAL HISTORY

The project of a history of The Medical Society of New Jersey and its component county societies is rapidly taking form. Enough material has been collated and arranged to make an imposing exhibit at the annual meeting. Collecting local items and mementos of medical nature is a project for which members of the Woman's Auxiliary are especially fitted, because of their education, their tastes, and their contacts with physicians. This project will be a worth-while incentive that will lead physicians to give their active support to the Auxiliary.

Read the editorials on page 136 and 189 of this Journal.

ANNUAL MEETING

The annual meeting of The Medical Society of New Jersey beginning on June 6, will visualize every phase of the experience of a practitioner of medicine in the State. The meeting has already begun in the preparation of the annual reports of the officers and committees which will be printed in the May Journal. A greater number of *progress* reports than ever before have already been printed in the current issues of The Journal. These reports will be summarized in the *annual* reports, and will be discussed by the delegates chosen from every county society.

The programs of the scientific sessions will include speakers with national, as well as local, reputations for presenting the newer phases of the relations of the medical profession to the people. To hear them will be an inspiration.

Then there is the opportunity to exchange views with your colleagues on all phases of the social relationship of every doctor to his fellows. Recreation that *re-creates* the mind and soul of the doctor is as important as his serious study of medicine.

Plan your time to include your presence at the annual meeting; and don't forget the inspiration which your wife will gain from her association with kindred spirits at the annual meeting of the Auxiliary.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

MARCH, 1939

7	Camden	10	Atlantic
7	Hudson	10	Salem
8	Mercer	14	Bergen
8	Ocean	15	Middlesex
8	Union	16	Gloucester
9	Burlington	16	Morris
9	Essex	22	Monmouth
9	Passaic		

APRIL, 1939

4	Camden	13	Somerset
4	Cape May	14	Atlantic
4	Hudson	14	Salem (Annual Meeting)
11	Bergen	18	Warren
11	Cumberland (An. Meeting)	19	Middlesex
12	Mercer	20	Gloucester
12	Ocean	20	Morris
12	Union (Annual Meeting)	25	Hunterdon (Annual Meeting)
13	Burlington	26	Monmouth (Annual Meeting)
13	Essex		
13	Passaic		

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held in the auditorium of the School of Nursing of the Englewood Hospital, Englewood, N. J., on Tuesday evening, January 10th, 1939. The meeting was called to order by the President, Dr. Chester A. King, at 9 p.m.

HOSPITAL WORK

President King presented the plan of repeating the Hospital Week and the special edition of the newspaper, both of which were features of the "Week" last year. (Jour., May, 1938, p. 333.)

SURVEY OF MEDICAL PRACTICE

The President also explained some points about the survey of medical service and urged the members to complete their forms as soon as possible.

APPOINTMENTS TO MEDICAL-DENTAL BUREAU

President King announced the following appointments to the Medical-Dental Bureau of Bergen and Passaic Counties: Drs. L. W. Metz, H. E. Reinhold, R. K. Tether, and H. B. Wilson.

A. M. A. INDICTMENT

Dr. Snedecor explained the indictment of the A. M. A. secured by the Federal Government. He urged all of us to prevail upon at least ten patients to write to Washington and tell their representatives to stop trying to make medicine a trade, and physicians political entities. If each doctor would succeed in getting ten grateful patients to help in this fight, it would create tremendous political pressure and would be worth far more than our individual efforts against the political tirade which is appearing.

SCIENTIFIC

Dr. John H. Keating, Cardiologist of St. Luke's Hospital, New York City, talked to us concerning

the background and newer aspects of coronary circulatory disease. He reviewed the history of the disease and discussed particularly the history of the study of angina pectoris. His paper was extremely interesting and went into all factors of coronary circulatory disease including the theories on the etiology, the pathology as best understood today, the signs and symptoms, and then a complete description of the differential diagnosis as concerns coronary circulatory diseases.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the City Dispensary Building, February 7th, 1939, at 9 p.m., President H. Wesley Jack, of Camden, presiding, and seventy-three members and guests present.

NEW MEMBERS

Dr. Paul A. Ironside, recently elected member, took the oath of membership and was introduced to the society.

Emanuel Sufrin, M.D., 119 North 27th Street, Camden, was elected to active membership.

M. M. Osmun, M.D., 611 Broadway, Camden, was elected to honorary membership.

SCIENTIFIC

The following reports were presented:

The Treatment of Simple Engorgement of the Lactating Breast, paper and demonstration, by Paul G. Ehner, M.D.

Impetigo Constagiosa, its treatment with an ammoniated mercury-colloidal kaolin lotion, report of a controlled study; by Arthur G. Pratt, M.D. Discussed by Drs. Decker, A. B. Davis and Betancourt.

Pregnancy in a Diabetic, by Alexander Ellis, M.D. Discussion by A. B. Davis.

TRUSTEE

Dr. Robert Gamon was unanimously elected as a trustee to succeed Dr. MacAlister, whose obituary was printed in the February Journal, page 120.

MEMORIAL

Dr. Sh'pman presented a resolution on the death of Dr. Alexander S. Ross. It was moved, seconded, and ordered that the resolution be adopted, and a copy sent to Mrs. Ross. (See Jour., Feb., p. 119.)

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

Some of the acute problems facing the medical profession were discussed before the *Cumberland County Medical Society* at the meeting held Tuesday afternoon at the Cumberland Hotel. Dr. Dare Woodruff, the President, presided.

SCIENTIFIC

Dr. E. M. Matsner, New York City, spoke on "Gynecological Problems, particularly Birth Control and Its Relation to the Family Doctor".

MEMBERSHIP

Dr. William C. Kratka, Bridgeton, was elected to membership.

Dr. Allan Harris, Greenwich, presented his resignation from the society on account of illness of long standing. He was made an honorary member.

HEALTH INSURANCE

The subject of health insurance was discussed at some length. The physicians were opposed to the system under direct government control or compulsion; but they generally favored a system which the patient entered voluntarily and was allowed free choice of doctors.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held at the Academy of Medicine, February 9, 1939, at 9 p. m., with President Kraker presiding.

SCIENTIFIC

Dr. Russell Cecil, New York City, gave an address on "The Serum Treatment of Pneumonia". He portrayed pneumonia as an emergency disease, usually easy to diagnose, but variable in its manifestations from year to year. Most cases are atypical, according to the descriptions of the disease in past years.

Dr. Cecil showed charts and lantern slides demonstrating the excellent results from an early diagnosis of the type of the infecting bacteria, and the early administration of the appropriate serum. He also said that the drug—693 sulph-pyridine—is especially efficacious in type three cases.

Dr. Edgar A. Lawrence, New York, described the good effects produced by sulph-pyridine 693 when it is administered early. He described the indications for the drug and the precautions to be observed in its use.

Dr. Arthur Fishberg spoke on the subject "The Heart in Pneumonia". With improved methods of treatment, heart failures are rare in pneumonia, and seldom occur in a patient whose heart was healthy at the onset of the disease. The most common cause of circulatory failure is oxygen deficiency.

NEW MEMBERS

The following members were admitted:

To active membership by election—

Chester B. Allen, Jr., Montclair
Aaron Lewis Kaminsky, Newark
Melville G. Kilborn, West Orange
Jane Reeve-Allen, Montclair
Henry V. Resch, Bloomfield
Herman Shilonsky, East Orange

To active membership by reinstatement—

William M. Brams, Newark
Adolph Flachs, Newark

To active membership by transfer—

From Union County:

Edward J. Moress, Hillside
Harold J. Orris, Hillside
Maxwell H. Shack, Newark

To associate membership—

Edward Ehrlich, Newark
Viola G. Fleischmann, Irvington
Werner Kornfeld, East Orange
Harold G. Kunz, Bloomfield
Sydney C. Lefkovich, Newark
Henry A. Luce, Orange
Frederick K. Poller, Newark

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Reported by Franklin J. Tobey, M.D., Secretary

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, January 19th, 1939, under the auspices of the Section on Obstetrics and Gynecology. The meeting was called to order by the President, Dr. Henry C. Barkhorn, at nine p.m.

NEW MEMBERS

The tellers of the election of new members reported that all the ballots were in the affirmative, and the President declared the following elected to fellowship:

Morris Fellman, M.D., Jersey City
Charles H. Garretson, D.D.S., Newark
Floyd E. Keir, M.D., Englewood
Ben B. Markowitz, M.D., Jersey City
Bernard M. Nielson, D.D.S., Hackensack
Franklin W. Rice, M.D., Morristown

Junior Fellow, Joseph A. Papalia, M.D., Union City

MATERNAL WELFARE CONFERENCE

Dr. Barkhorn welcomed the members of the State Maternal Welfare Committee, the Maternal Welfare Committees of the counties, and the Field Physicians, whose conference preceded the meet-

ing. The President called attention to the benefits derived from the close associations of these joint annual meetings, and called on Dr. William J. Carrington, President of the State Society, for a few words. Dr. Carrington expressed his appreciation of the excellent arrangements of the meeting and thanked Drs. Bingham and Barkhorn for making them possible.

DR. MARTLAND'S ADDRESS

Dr. Barkhorn introduced Dr. Gerald Hayes, Chairman of the Section, who introduced Dr. Harrison S. Martland, Chief Medical Examiner of Essex County. Dr. Martland's paper, "The Medical Examiner Looks at Obstetrics and Gynecology", reviewed his thorough knowledge and vast experience of the subject. The address was delivered with his usual humor, which makes his teaching entertaining to his audience. The lecture was illustrated with lantern slides, and some gross specimens were shown with the epidiascope.

The meeting closed with a rising vote of thanks to the guest speaker.

The stated meeting of the Academy of Medicine of Northern New Jersey was held on Thursday, February 16, 1939, under the auspices of the Eye, Ear, Nose and Throat Section. The meeting was called to order by the President, Dr. Henry C. Barkhorn, at nine p.m.

MEETING FOR LAYMEN

Dr. Barkhorn announced the meeting to the laity on Saturday, February 18th, and said he hoped the members would come and invite their friends. Dr. Henry E. Sigerist, Professor of History of Medicine at Johns Hopkins University, will be the guest speaker. His subject will be "Medicine as a Social Institution". The meeting is sponsored by the Committee on Public Health and Medical Education and the Health Committee of the Newark Contemporary.

NOMINATING COMMITTEE

Dr. Barkhorn appointed the following as the Nominating Committee of the Academy: William H. Areson, M.D., Chairman; Royal A. Schaaf, M.D., and Sidney C. Keller, M.D.

SCIENTIFIC PROGRAM

The President introduced Dr. Andrew Rados, Chairman of the Section. The paper of the meeting was "Modern Viewpoints in the Diagnosis of Brain Tumors"; and Dr. Rados introduced the first guest speaker, Dr. I. S. Wechsler, Professor of Clinical Neurology, Columbia University. Dr. Wechsler confined his remarks to the methods of diagnosis, the x-ray, air injection and the various symptoms.

Dr. Leo M. Davidoff, Assistant Professor of Neurology, Columbia University, and brain surgeon of the Jewish Hospital, New York, was the next speaker. Dr. Davidoff spoke of clinical localization by the use of the electro- or pneumo-encephalogram, and explained the advantages of each.

Dr. Cornelius G. Dyke, Assistant Professor of Radiology, Columbia University, continued the paper with some excellent slides of x-rays of the

various types of brain tumors, and explained the importance of the x-ray in diagnosing and locating them.

All the speakers used lantern slides to illustrate their remarks.

NOMINATING COMMITTEE

Dr. Rados appointed the Nominating Committee of the Section as follows: Drs. William H. Hahn, Chairman; E. Leroy Wood, and Nathan Zvaifler.

The meeting closed with a rising vote of thanks to the guests for their excellent addresses.

Program of the Academy of Medicine of Northern New Jersey for April:

SECTIONS

Council Thurs., April 6
Eye, Ear, Nose and Throat Mon., April 10
Medicine and Pediatrics Tues., April 11
Stated, auspices Surgical Section Thurs., April 20

Eye, Ear, Nose and Throat—Mon., April 10, 8:45 p.m.

"Cavernous Sinus Thrombophlebitis", William H. Hahn, M.D.

Medicine and Pediatrics—Tues., April 11, 8:45 p.m.

"Modern Concepts of Pathogenesis and Treatment of Baldness and Acne Vulgaris", Marion B. Sulzberger, M.D., Assistant Professor, Clinical Dermatology and Syphilology, Post-Graduate School, Columbia University.

Stated Meeting—Auspices Section on Surgery, Thurs., April 20, 8:45 p.m.

"Toxic Goitre", Elliott C. Cutler, M.D., Moseley Professor of Surgery Harvard University.

IRVINGTON PHYSICIANS' ASSOCIATION

Reported by M. W. Weinstein, M.D.

The municipality of Irvington is continuous with the western side of Newark. It has a population of over 50,000, among whom thirty-eight doctors are practicing. The Physicians' Association is a geographic group of doctors who are applying the social and economic principles of The Medical Society of New Jersey and the Essex County Medical Society to their own patients.—Editor's note.

On January 29th, 1935, at the request of Dr. E. W. Mierau, twenty-four physicians practicing in Irvington, N. J., decided to form a society. This meeting resulted in the *Irvington Physicians' Association*, whose objects and purposes were:

"To safeguard the best interests of the medical profession in order to prevent exploitation of the profession by any group or individual;

"To correct certain abuses that are constantly being imposed upon them;

"To familiarize the townsfolk with the necessity for the retention of the doctor-patient relationship and the dangers ensuing directly from its dissolution;

"To promote and further the professional, business and social interests of its members;

"To inculcate a spirit of helpfulness and good fellowship amongst them; and to provide them economic security."

GOOD FELLOWSHIP

The immediate and most profound effect was generalized acquaintanceship amongst all the local doctors. These men began to know each other personally, and learned to enjoy each other's company in a spirit of helpfulness and good fellowship. Sunday morning breakfasts were mutually enjoyed by groups of the local physicians; and at them topics of current medical interest were considered at round table discussions. Summer outings were arranged for as many of the society as desired to attend. The turnout at these events was surprisingly large, and comradeship reigned on these happy occasions. If good fellowship were the sole accomplishment of our organization, we feel that it would have been sufficient reason for its existence.

ADMINISTRATION OF MEDICAL RELIEF

It has often been charged that physicians are incapable of managing their own affairs. We point with pride to the following record of our accomplishments in the management of the Irvington relief problem as it affects the doctor:

When, in April of 1936, the State threw the relief problem back upon the individual municipalities, we had several conferences with Director Miller, who was then Mayor of Irvington. We requested that some provision be made for the free selection of physicians by the relief clients. With the coöperation of Mayor Miller a medical advisory committee of three doctors was formed, the chairman being also appointed to the Relief Council of Irvington. We feel that because our organization was functioning at that time, we were able to forestall what has happened in Newark and similar places where no local medical society was functioning.

With the inception of the local medical advisory committee the old E. R. A. set-up was used. Little by little, as the procedure was found faulty, changes occurred for their betterment. The following is a list of some of these changes.

1. The control of the medical advisory committee is vested entirely in the Irvington Physicians' Association.
2. Any physician who has any complaint about the administration of medical relief is assured a fair hearing.
3. Free choice of physicians is assured each relief client, even to the selection of outside doctors, if the patient has been using them for a prolonged period of time prior to coming on relief.
4. Relief clients are not permitted to go to free clinics, with few exceptions (tuberculosis, venereal, etc.).
5. The complicated system of filing relief blanks was simplified to one small slip for each call. There is no longer any necessity for filing monthly statements.
6. Physicians are paid for smallpox vaccination and diphtheria inoculations of relief children.
7. A dental advisory committee was formed by our efforts which functions in a manner similar to ours, and which coöperates with the medical advisory committee on joint problems.
8. Although the physicians' bills per se are higher than in those communities which use the

MEDICO-DENTAL RELIEF ORDER Irvington 288

Forward to RELIEF OFFICE within 48 hours

Patient..... Family Head.....
Address..... Municipality..... Case No....

R's DIAGNOSIS AND TREATMENT

Date of Home Visit	—	
Date of Office Visit		

Physician's Signature | Authorization
Address
I acknowledge receipt of Professional Service.
Signed
Client or Patient.

This form not to be issued by Physician except in Emergency or when Relief Office is closed. Void if not used within one week of issuance to client.

town doctor set-up, the ultimate saving to the town is easily apparent. Under our system the incidence of hospitalization per relief patient is greatly reduced.

9. The bills for visiting nurses' services have been greatly reduced by proper supervision and control.

10. Patients are admitted to nursing homes only on recommendation of the advisory committee, and are periodically checked. Insanity and feeble-mindedness are properly placed. This results in a further saving to the community.

11. There is cordial coöperation between the Local Assistance Board and the member doctors.

12. The relief patient, the Local Assistance Board and the individual physicians are all gratified with the medical procedure as it now stands.

COUNTY MEDICAL SOCIETY

Our association has sponsored and obtained a wider representation on the council of the county medical society. This has resulted in better local understanding.

FORMATION OF OTHER LOCAL ORGANIZATIONS

We were directly responsible for the organization of the following local societies:

1. Bloomfield Physicians' Association.
2. Belleville-Nutley Physicians' Association.
3. Irvington Dentists' Association.

VISITING NURSES' ASSOCIATION

We were instrumental in securing the coöperation of the State Medical Society for the better control of visiting nurses.

MEDICAL W. P. A. PROJECTS

The proposed projects of the medical Works Progress Administration were carefully studied by special committees of the association in coöperation with the health director. Our association voted, after these deliberations, that there was no need for them in our community.

COMMUNITY CO-OPERATION

A very satisfactory understanding and coöperation now exists between the municipal authorities and our association.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* held its regular monthly meeting at the Homestead, Woodbury, on Thursday evening, February 16, 1939, with the President, Dr. William Crain, of Woodbury, presiding and an attendance of twenty-five members and five guests.

POST-GRADUATE LECTURES

Dr. Henry B. Diverty, Chairman of the Committee on Post-Graduate Training, reported that the series of lectures being given this year were well attended and that the Gloucester County Medical Society was creditably represented in the course.

TUBERCULOSIS TESTING

Dr. I. W. Knight, of Pitman, Chairman of the Public Health Committee, reported that the supervising principals and the high school principals had been interviewed concerning tuberculosis testing and x-raying. He stated that the Gloucester County Health Association is prepared to start the work in the high schools, and that a set of forms is being prepared by his committee for use in this work.

Dr. Knight further reported that the authorities at the Glassboro High School were desirous of having not only the upper classes tested and x-rayed, but the entire enrollment, including the teaching staff. This work will be under the supervision of Dr. William Pedrick, of Glassboro.

SCIENTIFIC

Dr. William Bates, of the Post-Graduate School of Medicine at the University of Pennsylvania, spoke on "The Pseudo-Surgical Abdomen".

At the conclusion of a most interesting and instructive presentation, a very informative motion picture was shown.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The Annual Dinner of the *Hudson County Medical Society* was held on February 1, 1939, in the Carteret Club, Jersey City. An excellent program of speakers and entertainers was carried out.

Guests attending the dinner were:

H. Wesley Jack, President of Camden County Medical Society
David A. Kraker, President of Essex County Medical Society
Elmer J. Elias, Vice-President Mercer County Medical Society
Henry Cotton, Mercer County Medical Society
C. Byron Blaisdell, President Monmouth County Medical Society
Albert W. Pigott, Vice-President Somerset County Medical Society
James H. Spencer, President Sussex County Medical Society
Chester I. Ulmer, Secretary, Gloucester County Medical Society, and Councilor, Fifth Judicial District

William G. Herrman, Past-President, The Medical Society of New Jersey
Bernard McMahon, delegate from Morris County

Also Trustees of The Medical Society of New Jersey:

Ralph K. Hollinshed
Watson B. Morris
Alfred A. Stahl
Elias J. Marsh
Andrew F. McBride
Samuel Alexander
William F. Costello

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, February 7th, 1939, at the Carteret Club. The meeting was called to order by the President, Dr. Reeve L. Ballinger, at 9:35 p.m.

HONORARY MEMBERSHIP

Dr. N. M. Alter moved that we approve the recommendation of the Executive Committee that Dr. George Wilkinson be made an Honorary Member of the Hudson County Medical Society. Seconded by Dr. J. F. Londrigan, and carried.

SCIENTIFIC

Dr. Josephine B. Neal, Associate Director of the Bureau of Laboratories, Board of Health, New York City, and Clinical Professor of Neurology, Columbia University, spoke on "Diagnosis and Treatment of Acute Infectious Diseases of the Central Nervous System in Children". Her talk was illustrated by lantern slides. Discussors: Drs. Kerdasha and Stockfish.

Dr. Frederic E. Elliott, Chairman of the Medical Economics Committee of the Medical Society of the State of New York, spoke on "Medical Expense Indemnity". Discussors: Drs. Evans and Maras.

PUBLIC HEALTH COMMITTEE

Dr. A. E. Jaffin, Chairman, gave the following report:

"The Public Health Committee held a meeting recently which was attended by approximately ten members. I feel confident that there are many men on this committee who have obligations and duties to perform, which make it rather difficult for them to be active on this committee. I therefore ask the President to consider the appointment of men who would be better able to serve on this committee.

"The Public Health Committee has no report to make tonight, but we will have a report at a subsequent meeting."

MEMBERSHIP COMMITTEE

Dr. W. T. Callery, Chairman of the Membership Committee, stated that there was a meeting of the committee whereby it deliberated on ways and means of having delinquent members pay their dues. There are at the present time 300 paid-up members, and approximately 160 delinquent members. The members of the committee will contact the delinquents, and will make every effort to have a membership that will equal, if not surpass, last year's membership.

Dr. Callery stressed the importance of every doctor paying his dues on or before March 10th, as the Official List of The Medical Society of New Jersey closes on that date, and the member's name will not be carried on the Official List after this date. The delinquent physician loses his membership in his own county society, in The Medical Society of New Jersey and in the American Medical Association, and will probably have his malpractice insurance affected.

PUBLICITY COMMITTEE

Dr. W. Jay Snyder: "It has been suggested to us by The Medical Society of New Jersey that we inaugurate an advertising campaign for the glorification of medicine. The Publicity Committee studied it seriously and think it is a very fine idea. However, the cost of that campaign would be a minimum of \$3000.00 a year. Each member would have to be assessed \$5.00 or \$6.00 in order to put this matter over. The committee is anxious to know what we are going to do in the matter, and will prepare a report on the subject.

LIBRARY COMMITTEE

Dr. N. M. Alter: "Three years ago the Hudson County Medical Society appropriated \$100.00 per year for subscriptions to journals and the purchase of books. The President at that time, Dr. Chapman, appointed a committee in charge of the library. It is obvious that the appropriation has to cover also the expenses of binding, cataloging, plates, etc.; and therefore, subscriptions were not started until last year in order that the fund might be allowed to increase. At the present time, 400 bound volumes are available. The Society was very fortunate to obtain the generous support of Dr. O'Hanlon, Director of the Medical Center, who not only gave us library facilities but also the services of a librarian. The library is expected to open in the immediate future. Detailed information will be published in the Bulletin from time to time. At this time again appeal has to be made to all the members of the Society to support this important means of post-graduate education by helping to obtain bequests, as well as by personal donations. Any book or Journal will be gratefully received and marked by a plate with the name of the donor."

NEW MEMBERS

The following physicians were elected to membership:

Dr. Lucy E. Boland, Arlington
Dr. Daniel S. Cieri, Union City
Dr. Edward D. Fenimore, Jersey City
Dr. Joseph F. Londrigan, II, Hoboken

Five physicians were proposed for membership.
Meeting adjourned 12:05 a.m.

MIDDLESEX COUNTY

Howard Dieker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, January 25, 1939. The Vice-President, Dr. B. F. Slobodien, called the meeting to order at 9:30 p.m.

SCIENTIFIC

Dr. George A. Harrop, director of Squibb's Research Institute, gave an interesting talk on the "Recent General Trends in Hormone Therapy".

A motion was adopted that the salary of Miss Kidd, the secretarial assistant, be increased from \$15.00 to \$20.00 a week.

Dr. Calvin brought to the attention of the society the opening of a baby keep-well and maternal clinic run by Allgair's Dairy at South River, N. J. Dr. Rowland moved that the society go on record as being opposed to this clinic. Dr. Karshmer seconded this motion, and it was passed.

Dr. Haywood moved that the society refuse to lend its projector to anyone. This motion was seconded by Dr. Spencer and passed.

Dr. Mark moved that a letter be sent to the Board of Freeholders asking it to abolish the fee that the society has been assessed for the use of the meeting room at Roosevelt Hospital. The motion was passed.

The meeting was adjourned at 11:20 p.m.

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, on February 15, 1939. The meeting was called to order by the Vice-President, Dr. B. F. Slobodien, at 9:30 p.m. There were thirty-six members present.

SCIENTIFIC

Dr. Alexander Gettler gave an interesting address on "The Role of Toxicology in Medico-Legal Medicine".

NEW BUSINESS

Dr. Marshall Smith moved that the society grant to the Bio-Photography Department of Rutgers University a donation of \$300.00 for the purpose of constructing a portable dolly to be used in the making of teaching films. There was no second to this motion. It was then moved that a committee be appointed to consider this request and that it report back at the next meeting. Dr. Henry Jr., Dr. McKiernan, and Dr. Haywood were appointed to this committee.

A communication was received from the Board of Freeholders advising us that the charge for the meeting room at Roosevelt Hospital is levied by the Board of Managers of the Hospital.

The meeting was adjourned at 11:00 p.m.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held on Wednesday night, January 25th, 1939, at the Nurses' Home of the Monmouth Memorial Hospital in Long Branch, New Jersey. Because of the bad weather conditions there was a rather small attendance.

Visiting guests were Dr. LeRoy Wilkes, Executive Officer, and Lt. Col. Norman M. Scott, M.D.

SCIENTIFIC

Dr. William G. Herrman, Chairman of the State Cancer Committee, was guest speaker of the eve-

ning. He presented a paper entitled "Why Cancer Should Be of Interest to the General Practitioner".

Discussions followed by Dr. Cerita de Pons, who discussed Dr. Herrman's paper from the pathological viewpoint; Dr. Joseph Wiener, the medical viewpoint; and Dr. O. R. Holters, from the surgical viewpoint. The meeting was then thrown open for general discussion by the group as a whole.

Dr. Barclay Moffat, Red Bank, spoke of the receipts for infantile paralysis cases derived from the President's Ball, and suggested that a Hubbard type of tank for Fitkin Hospital's use be purchased from this fund.

NEW MEMBER

Dr. Donald G. Reynolds, Freehold, was elected to membership.

The meeting was adjourned about 11:30 o'clock, and a collation was served by the nursing supervisors of the hospital.

EXECUTIVE COMMITTEE MEETING

A meeting of the Executive Committee was held at the Monmouth Memorial Hospital, Long Branch, on Monday evening, January 9th, 1939. The meeting was called to order by the President, Dr. C. B. Blaisdell, at nine o'clock. Those present were Drs. Blaisdell, MacKenzie, Gosling, Kazmann, Moffat, and Clark.

Dr. Blaisdell was authorized to appoint a committee from the Public Relations Committee to meet with a committee from the Woman's Auxiliary to set up a program for the coming year.

A. M. A. SURVEY

Only twenty-one "I. F. A. forms" were returned from the first one-week spot survey. These showed that 19 per cent of the calls made by the doctors of Monmouth County were free. I. F. B. forms for the second survey were enclosed with the monthly "Bulletin". There is yet to be a third set of I. F. forms. We should try to cooperate as well as possible, and see that they are correctly filled in and returned as instructed.

VENEREAL DISEASE

Practically all of the men, fourteen members, on the list of those approved for working in the venereal disease clinics have had special training through the courses offered by the State Department of Health, either under John Stokes, M.D., in Philadelphia, or in the Orange Memorial courses under Dr. Robert Sellers. Appointments for this year will be confirmed at a meeting of the County Venereal Disease Committee on Wednesday, January 25th. In some instances these have been rotated every six months in order to give more men an opportunity for participating in the work. A few more alternates for those already on the State Department of Health's approved list may be soon necessary; and any doctors interested in this work who are willing to avail themselves of the opportunities for further free education in treating syphilis had best make application in writing to Dr. D. M. P. Magee, Chairman of our County Society Venereal Disease Committee. This application on the part of the doctors is necessary

before our society can recommend them through the State Society office to the State Department of Health. The remuneration is five dollars per clinic hour, and the total amount receivable by one doctor in one year is five hundred dollars, or two clinic hours per week.

INFANTILE PARALYSIS

It would not be untimely for us to show some interest in the President's Ball to raise funds for the control or treatment of infantile paralysis. We have in our treasury over eight hundred dollars derived from Asbury Park's observances in the past two years, which can be used at the time of any future epidemic or in securing apparatus for the treatment of post-epidemic victims already in the county. At present, Dr. Moffat, with the approval of the Committee, is studying the advisability of providing a locally made Hubbard tank for use in the Fitkin Hospital. One is already in use at the Monmouth Memorial Hospital, and is used about one-half of the time, only part of which is for infantile cases. It is open to discussion whether another such piece of apparatus is needed in a county of this size. From previous birthday ball funds raised in Long Branch, apparatus worth \$125.00 and \$135.00 has been furnished Monmouth Memorial Hospital.

The regular monthly meeting of the *Monmouth County Medical Society* was held on Wednesday, February 22, 1939, at the Molly Pitcher Hotel in Red Bank, New Jersey, at nine o'clock.

SCIENTIFIC

The scientific program consisted of a paper entitled "Pneumonia and Other Respiratory Diseases", which was very ably presented by Dr. Hobart Reimann, Professor of Medicine, Jefferson Medical School. He discussed the various epidemics of influenza since the pandemic of 1918; and reviewed the types of pneumonia, discussing serum treatment and, as well, the more recent contribution of the sulphanilimides in pneumonia therapy.

Dr. Carlos Pons led the discussion, followed by Drs. Altschul, Edelson, Knapp, and Albright.

NEW MEMBERS

The following men were admitted to membership in the society: Drs. Ralph Ciampa, Long Branch, and Sidney Hodas, New Jersey State Hospital, Marlboro.

CONSULTATIONS

A business meeting was then held, and the chief topic of discussion was what the attitude of the organization of medicine should be in relation to osteopathy and, particularly, as to the ethics of consulting with an osteopath.

STAFF CONFERENCES

The regular staff conference of the *Monmouth Memorial Hospital* was held on February 7th. The scientific program consisted of a presentation of cases of tularemia, recto-sigmoidal cancer, and the use of sulphopyridium in the treatment of pneumonia.

The regular staff meeting of the *Fitkin Memorial Hospital* was held at that institution on February 20th. The chief presentation was a case reported by Dr. Raoul Pietri on the diagnosis of a metastatic cancer of the brain. The operation and autopsy findings were described.

COMMITTEE MEETINGS

Executive Committee.—A meeting of the *Executive Committee of the Monmouth County Medical Society* was held at the Fitkin Memorial Hospital, Neptune, on Monday evening, February 13th. The meeting was called to order by the President, Dr. C. B. Baisdell, at nine o'clock. Members of the committee present were Drs. Baisdell, MacKenzie, Kazmann, K. G. Brown, Albright, Clark, Moffat, Pregnall, and Featherston. Also attending the meeting were Drs. Fisher, Miller, and Watkins.

Adult Health Committee.—Dr. Miller reported on a recent meeting of the Adult Health Committee and the following suggestions are offered for the consideration by the society:

1. The committee recommends a program of paid advertising by the society to give publicity to, and to encourage, periodic health examinations.

2. That each physician interested in this type of work make use of the forms which may be obtained through the offices of the County Medical Society.

3. That the laboratory work, x-ray, or specialistic examinations, which may be desired as a result of such periodic check-up, be made available to the patient at reduced fees.

Public Relations Committee.—Dr. James A. Fisher reported for the *Public Relations Committee* that the cost of the paid advertising campaign, as suggested by the State Committee, would be over \$4.00 per member and the committee does not believe that this type of campaign is indicated at this time.

COMMUNICATION FROM THE PRESIDENT

1. REVISION OF CONSTITUTION AND BY-LAWS

It is important that our County Medical Society proceed in all its activities in conformity with its Constitution and its By-Laws. A committee is now studying the needs of our society in the light of its increasing growth, which affects quorum numbers, and the size of standing committees; also because of our increasing liaison with the government, State, and county administrations in behalf of public health and disease problems; and finally to remedy some inconsistencies which have arisen because of previous amendments.

2. SIGNING THE CONSTITUTION

Chapter I, Section 9 states: "Membership in this Society shall be considered consummated only after affixing his or her signature to these By-Laws."

Membership confers privileges as well as placing obligations upon those enjoying it. We are bound together by a heritage of knowledge and ethics that is strengthened by our making for ourselves a society of "Those who recognize each other as associates and friends". We acknowledge this by signing our names, emphasizing certainly the inherent strength and ultimate value of those ties, even though we cannot all be in harmony with the ideas of practice at all times. Let us individually,

just as we sign, review our ethics from time to time, for the good of our society and its preservation (now being assailed!). This practice of affixing our signatures has been neglected, and becoming a member has lost some of its just significance. It will be revived, opportunely enough, on Washington's Birthday meeting. Let's have a large attendance.

3. COURTESY

Your President and Dr. W. G. Herrman were cordially entertained by the Hudson County Medical Society at its January banquet in the Carteret Club, Jersey City, along with officers of several other county societies. An excellent address was given by an outstanding member of the legal profession relative to our position in the economy of the State and nation.

4. WOMAN'S AUXILIARY

Notice of the disbanding of our Woman's Auxiliary was given to the society this past month, because of no immediate need or program for continuation. It will be resumed, according to the President, Mrs. H. H. Freedman, of Freehold, at any time when it is really needed. We must thank the ladies for what they have done and for their success in having kept their organization ready so long in order to help if needed.

(Note the editorial on page 189 of the department of Woman's Auxiliary—Editor's note.)

A. M. A. SURVEY

Dr. Robert Watkins reported on the results obtained for the first week of the A. M. A. Survey of medical care. A copy of the summary sheet for Monmouth County was submitted for our file. The original was sent to the American Medical Association, and a copy to The Medical Society of New Jersey.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A meeting of the *Morris County Medical Society* was held the evening of February 16th at the Greystone Park Hospital, with President Thomas presiding over a generous attendance of members and guests.

Routine business included a report on the progress of the Uniform Practice Act.

THE CURIE INSTITUTE

The President then introduced Mrs. Agnes G. M. Peabody, Chairman of the Executive Committee of the Curie Institute, who made an excellent presentation of the functions of the Curie Institute and what it is hoped to accomplish for the State. Facilities for the care of cancer patients being inadequate and a State-owned cancer hospital being opposed, the Institute, which was organized six years ago as a voluntary and non-profit organization, hopes to carry out a four-fold plan similar to the Swedish plan, including:

1. A parent hospital near a large center of population, probably Newark, but available to all physicians of the State.

2. At least five grams of radium and a radium emanation plant.

3. Model cancer centers to be conducted in connection with existing hospitals where all classes of patients will be admitted and fees rated, and which will also serve as a training center for the physicians.

4. Homes for homeless and hopeless cancer cases, where it is believed an average of 250 to 300 cases can be cared for.

The Curie Aid, a women's auxiliary, is composed of workers to collect funds for this purpose. Mrs. Peabody took up several objections which had been raised to this plan and stated that the Institute was not asking for an assignment of assets of co-operating institutes; that every patient would not have to come to one center when local doctors would be unable to diagnose or treat cancer; that a lay board of trustees would not pass on treatment; and that the Institute does not refuse to submit to the supervision of the State. Several minor objections were also taken up and shown to be misleading. Mrs. Peabody closed her presentation with a plea for cooperation and a better day for the cancer patient.

Dr. Joseph H. Kler, Chairman of the Public Relations Committee of the State Medical Society, who is promoting better treatment for cancer patients, gave a fair, unbiased and evenly balanced address on how this question could best be met.

Discussion was entered into by Dr. McBride, Dr. Arenson, Dr. Herrman and Dr. Wilkes, and by Dr. Mills, Dr. Costello, Dr. Pinckney and others of the local society. The consensus of the discussion was that, since cancer is such an important health problem, there is room for all who wish to help in this work.

Refreshments were served in the hospital cafeteria.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The fifth Clinical Conference of the *Passaic County Medical Society* was held at the Barnert Memorial Hospital Nurses' Home, Paterson, on Monday evening, February 6th, 1939, with an attendance of about one hundred members.

Program, Dr. J. Stark, Paterson, Chairman:

Dr. J. Greengrass, Case of Angioneurotic Edema
Dr. D. Shapiro, Case of Osteoma of the Orbit
with Recovery

Dr. L. G. Shapiro, Case of Adhesive Pericarditis

Dr. W. Spickers and Staff, Three Cases of Granuloma of the Gastro-intestinal Tract

Dr. Sandor Levinsohn, Case of Xanthomatosis (Schüller-Christian syndrome), associated with Diabetes Insipidus

Drs. Wassing and Ehrlich, Case of Meningioma with Aphasia

Drs. Bender and Weintraub, Case of Neurofibroma of the Pleural Cavity

Dr. Mendelsohn and Staff, Case of Multiple Carcinomata of the Stomach with Recovery

The pathology of the clinical material was discussed by Dr. Gladstone.

After the meeting a collation was served.

The regular monthly meeting of the *Passaic County Medical Society* was held at the Passaic City Club, Passaic, February 9th, 1939, at 9 p.m., with the President, Dr. L. G. Shapiro, presiding.

NEW MEMBERS

The following new members were admitted:

To active membership—

Dr. E. A. Calligaro, Clifton, N. J.

Dr. Benj. Provisor, Passaic, N. J.

To associate membership—

Dr. B. F. Alpren

Dr. E. S. Balles

Dr. I. L. Fishbein

Dr. Henry Michelson, all of Paterson

SCIENTIFIC

The scientific section was under the direction of the Committee on Mental Hygiene.

Dr. Shapiro introduced the first speaker, Dr. Karl M. Bowman, Director of the Psychiatric Division, Bellevue Hospital, New York, whose subject was "The Modern Treatment of Schizophrenia". This paper reviewed the various forms of treatment for this disease until Sakal, of Vienna, introduced insulin treatment.

At Bellevue both the insulin and metrazol treatments were used with splendid results in early cases.

Discussion by Dr. Warren, Drs. Smith and Sutton, of Overbrook Sanatorium, and Dr. Peacock, of Greystone Park.

The second speaker was Stephen P. Jewett, M.D., Professor of Neurology and Psychiatry, Metropolitan Hospital, New York, whose subject was "Neuropsychiatric Aspects of General Surgery".

Dr. MacGuffie briefly discussed this talk, and the meeting then adjourned.

SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The January meeting of the *Summit Medical Society* was held at the Nurses' Home of Overlook Hospital on Tuesday evening, January 31st.

Dr. Hallock, the President, presided, with twenty-three members and nine guests present.

Dr. Edward F. Roberts, of the Lederle Laboratories of New York City, presented the film on "Pernicious Anemia", which was exceptionally instructive and presented an interesting picture of the modern treatment of the various forms of that blood disorder. A general discussion followed this presentation.

Following the meeting a collation was served.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The regular Winter meeting of the *Warren County Medical Society* was held in the Elks Club rooms, Phillipsburg, N. J., January 17, at eleven o'clock, and was called to order by the President, Dr. C. F. Smith, of Washington.

MEDICAL SURVEY

Dr. LeRoy Wilkes, Executive Officer of the State Society, spoke on medical economics. He introduced Dr. Norman N. Scott, Assistant Executive Officer of the State Society, who then spoke on the medical survey which is made by the State, and urged that all physicians fill out Form 1 F and return to the State Society not later than February 15th.

BIRTH CONTROL

Mrs. Bolton Love, of Easton, Pa., was present and spoke on birth control as conducted in the

Easton Clinic, and urged that the society sponsor a clinic in Warren County or in conjunction with the Easton Clinic.

Dr. Wilkes answered several questions asked by the members concerning the reaction of the State Society on birth control. He stated that the Society was studying the subject.

It was then moved and seconded that the subject of birth control as presented by Mrs. Love be laid on the table for further study.

The meeting then adjourned to the Elks Club dining room where luncheon was served to the doctors and the Ladies' Auxiliary.

BOOK REVIEWS

MENTAL THERAPY. By Louis S. London, M.D., Assistant Physician at the Central Islip State Hospital, New York. 774 pages, 2 volumes. Covici-Friede, New York, 1938. Price \$12.50.

"The sale of this work," says the prospectus, "is positively restricted to physicians, lawyers, ministers, educators, and social workers." This restriction, however, being enforced by the retailers rather than the publishers, is of doubtful stringency. It is, furthermore, of questionable value, since none but the well-trained psychoanalyst will be able to find anything helpful in the volumes. In spite of the title "Mental Therapy", London makes little effort to describe the technic of treatment. In the 774 pages, housed somewhat unnecessarily in two volumes, the author gives histories of fifty cases. In each case the description of the patient's symptoms, dreams, and responses to analytic associations take up the bulk of space, while the treatment methods and the results receive scanty attention. The cases are described in sufficient detail to exhaust both the topic and the reader, and there is over-emphasis on lascivious details. Rushing in where angels fear to tread, London does not hesitate to psychoanalyze schizophrenics and manic-depressives. Of the fifty cases, only eleven are psychoneurotics. Eleven more are sexual perverts, and the remaining twenty-eight are psychotics.

To a psychoanalyst, the material is interesting; and because of the wealth of detail, the analytically expert reader will be able to match his interpretations against the author's. To the layman, or to the physician untrained in analysis, the work is nothing but a collection of case histories crowded with concupiscent circumstances.

HENRY A. DAVIDSON
Newark, N. J.

PRINCIPLES OF PHARMACY. By Henry V. Arny, Ph.M., Ph.D., with the collaboration of Robert P. Fischelis, B.Sc., Ph.M., Ph.D. 4th ed. Saunders, 1937. \$8.00.

This work, first published in 1909, has been recognized for twenty-seven years as an authority in

the field of Pharmacy. The first three editions were the personal work of Dr. Arny. In this fourth edition he has been ably assisted by Dr. Fischelis, Secretary and Chief Chemist, Board of Pharmacy, State of New Jersey, who has rewritten chapters 1-52 and done a large amount of the checking necessary to bring the subject down to date.

This edition is based upon the new edition of the United States Pharmacopoeia (U.S.P. XI) and the National Formulary (N.F. VI). It includes in its scope the newest and most useful knowledge of all drugs and chemicals of today. Particular attention has been given to synthetic chemicals and endocrine preparations.

The material is well arranged in a systematic manner in which the pharmaceutical processes are separated from the galenicals of the Pharmacopoeia, and the inorganic and organic chemicals used in pharmacy. Special sections are devoted to chemical testing and the prescription in all its phases.

This important book should be of use to the physician as well as to the pharmacist.

J. F. B.

PNEUMONIA AND SERUM THERAPY. By Frederick T. Lord, M.D., Clinical Professor of Medicine, Emeritus, Harvard Medical School; Member of the Board of Consultation, Massachusetts General Hospital; and Member of Massachusetts Advisory Committee on Pneumonia, 1931-1935; and Roderick Heffron, M.D., Field Director, Pneumonia Study and Service, Mass. Dept. of Public Health, 1931-1935. New York: The Commonwealth Fund; London: Humphrey Milford: Oxford University Press, 1938.

This is a revised edition of a book published first under the title "Lobar Pneumonia and Serum Therapy" in 1936. The title has been changed since it has been proven lately that specific serum therapy is applicable to bronchopneumonia as well. "Among the more important changes and additions are the inclusion of an outline of basic plans for comprehensive pneumonia control programs as community projects; further data on the incidence of types

of pneumonia; case fatality rates in the more common types of pneumococcus infection, and the results of antiserum treatment in a larger series of cases due to certain of the higher types."

A new dosage as a consequence of wider experience is recommended and the rabbit serum treatment is outlined. The chapter on precautions before giving the serum is of special interest. The authors claim that the danger of injecting horse serum intravenously is small. Of 1755 patients treated with horse antiserum, death due to the use of horse serum occurred in six (0.3%). Three of these deaths were caused by allergic shocks, and three by thermal reactions. A history of horse asthma or horse vasomotor rhinitis is essential, also a history of asthma and hay fever unrelated to horses. The incubation period of sensitiveness, the development of sensitiveness, the tests for sensitivity are discussed. The same precautions as to horse serum apply to rabbit serum. Tests are not infallible. The intradermal test is more sensitive than the ophthalmic test.

Some patients develop signs of hypersensitiveness even after a very slow intravenous injection in spite of negative ophthalmic and skin tests. If the ophthalmic test is positive, or if the intradermal test is strongly positive, the serum should not be used. A negative ophthalmic test and a positive skin test with a history of allergy is a contraindication to serum therapy. In cases with a negative history and doubtful ophthalmic and skin tests, serum should be given only six minutes after five to fifteen minims of adrenalin (1:1000) have been injected. One should not rely on desensitization. Such attempts are unreliable and do not guarantee against accidents. In spite of the well-known favorable results of serum treatment, failures are not unavoidable. "Chief of the avoidable causes of failure is the delay before the beginning treatment."

FELIX BAUM, M.D.

INTERNAL MEDICINE, ITS THEORY AND PRACTICE. In contributions by American Authors. Edited by John H. Musser, B.S., M.D., F.A.C.P. Third Edition. Published by Lea & Febiger, Philadelphia. Cost \$10.00

This book has been carefully revised. It contains 1391 pages and has twenty-nine contributors. The print is clear and the paper and binding durable.

Throughout the text physiology and pathology are stressed in diagnosis and treatment. The style is clear and forceful, with a minimum of superfluous discussion. References are listed at the end of each disease subject. This, plus an excellent index, makes it an ideal reference book. It also has all the newer developments in treatment.

The wealth of information that this text contains and its simplicity in presentation makes it ideal for student, practitioner or specialist.

T. W. HOWELL, M.D.

BABIES ARE HUMAN BEINGS, by C. Anderson Aldrich, M.D., and Mary M. Aldrich. Index and 124 pages, illustrated. New York, The MacMillan Company, 1938. Cloth, \$1.75.

Every parent can learn something valuable from the book "Babies Are Human Beings", because Dr. Aldrich and his good wife are *parents* as well as *scientists*. They speak from an extensive experience based on scientific principles and procedures. This approach insures a practical understanding of the child's growth and development, both physically and mentally; and also of the reasoning processes followed by the child. Without the latter a child's good intentions are often overlooked, and his very appropriate actions misinterpreted and misjudged.

Parents who read this book can see with clearer vision many things which puzzled them heretofore. The viewpoint is broader than a purely medical one. Chapters three and four are especially valuable to young parents with their first child, and chapter ten on "Do's and Don't's" is both sound and sensible.

In this day of too much "Advice" from too many sources—some of questionable authority—this little book by Dr. and Mrs. Aldrich is a good anchor to which the younger parents especially can safely hold.

LEROY A. WILKES, M.D.

A review of THE PHYSICIANS' BUSINESS, by George D. Wolf, M.D. J. B. Lippincott Co., Philadelphia; price \$5.00.

This book deals primarily, as its title indicates, with the business procedure in the doctor's office rather than with his professional technic as taught in the medical schools.

There is a real need for such a book, especially for the younger doctor just starting out, or while he is serving his internship.

Much of the information contained in this book should be more systematically taught in the medical schools. Dr. Wolf also emphasizes the need for the modern doctor to appreciate the many other opportunities beside private practice which are available to the medically trained man today.

All forms of medical practice require professional training and technic to insure good service, and business methods for distributing these services effectively, economically, and adequately to the public. Physicians who have confined their interest to the purely professional side of medical practice will find valuable pointers on such subjects as forensic medicine, insurance, records, accounting, together with the brief and enlightening discussions on the current trends in medical practice, the preparation and delivery of professional papers and addresses, and various types of medical careers.

The subject of fee schedules for professional services is one on which many differences of opinion as to their value and wisdom may be found.

L. A. WILKES, M.D.

THE THYROID AND ITS DISEASES, by J. H. Means; published by J. B. Lippincott Co., 1937.

From the pen of the director of the Thyroid Clinic of the Massachusetts General Hospital comes a text book on diseases of the thyroid gland which, to all except those interested only in surgical technique, is the most satisfactory of any issued to date.

The contents are divided into twenty-three chapters covering 578 pages. Each chapter is followed by a bibliography not only extensive, but also up to date, including references to 1936 publications. The first 100 pages are devoted to anatomy, histology, chemistry, and physiology of the gland and its secretion. The chapters of greatest interest concern toxic goiters, discussed in great detail in about 200 pages, which Means classifies into three types; exophthalmic or Graves'; toxic adenomatous or Plummer's; and intermediate or (on one occasion) bastard. Incidentally, this latter is only one of a number of humorous touches which provide delightful relief, and which seem to bring the author closer to the reader.

The discussion is eminently practical throughout, as one would expect from the chief of a general medical service and an active practitioner. Hence the last three chapters on Thyroid Administration in Diseases of Other Than Thyroid Origin, Thyroidectomy in Diseases of Other Than Thyroid Origin, and Fact and Fancy in Matters Thyroid.

SAMUEL BERG, M.D.

LEUKEMIA AND ALLIED DISORDERS, by Claude E. Forkner, A.M., M.D. Cloth, \$5. Pp. 333, with 79 illustrations. The Macmillan Co., Publishers.

With much interest any book that bears the name of Claude E. Forkner will be read by the profession. His long experience in teaching, together with his excellent knowledge of internal medicine and pathology, would make any of his publications worth while.

In this monograph on the intensely interesting subject of leukemia he has given a definite contribution not only to the hematologist but to the clinician as well.

The chapter on pathologic physiology is most interesting. His explanation of the mechanism of the anemia, leukocytosis, and leukopenia in leukemia is most instructive.

He has presented in detail a number of disorders in relation to leukemia such as pseudoleukemia, chloroma, leukosarcoma, and the leukemoid states.

He devotes a brief chapter to leukemia in children, stressing the maximum incidence of acute leukemia in the first five years of life when chronic leukemia is exceedingly rare.

Although the author contends little can be done for acute leukemia, he devotes an entire chapter to the treatment of the chronic forms of the dis-

ease. Every known method of treatment is thoroughly considered and appraised. The technic of treatment with Roentgen rays is most comprehensive.

The book abounds in many illustrative figures with a section of color plates where the various blood cells found in the different types of leukemia are pictured and described.

Although the numerous references to the exhaustive bibliography, some sixteen hundred in number, were sometimes annoying to the reader, they represent an intensive preparation for this noteworthy manuscript.

Be sure and include "Leukemia and Allied Disorders" on your reference shelf.

HARROLD A. MURRAY, A.M., M.D., F.A.A.P.

SYPHILIS, GONORRHEA AND PUBLIC HEALTH, by Nels H. Nelson and Gladys L. Crain. Cloth, \$3. Pp. 359. Macmillan.

This is a clear and readable work, presenting in simple language the entire problem of the genito-infectious diseases. It is essentially by and for public health workers, but no one concerned with these conditions can fail to benefit from reading it. Many of the illusions of the medical profession and the laity are dispelled.

The sections devoted to treatment are well written and complete. They might well be used as a primer for anyone who intends to treat these diseases. The plea for standardization of treatment may well be heeded.

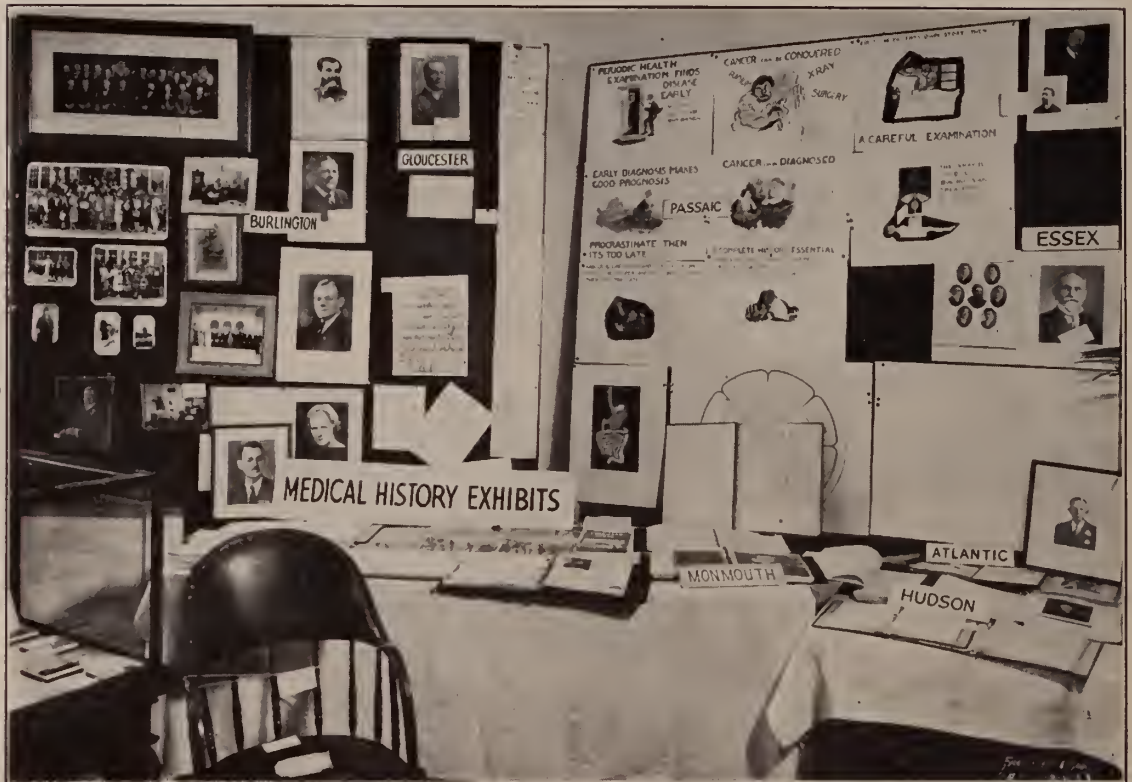
While admitting that the entire problem eventually resolves itself into one of social hygiene, the authors realize the futility of seeking an immediate Utopia, and consequently they try to resolve the problem into its component parts. They stress those elements which can be successfully attacked at present, such as treatment, communicability, and a program for control, showing how each may be operated to the best advantage. They indicate the separate and interlacing responsibilities of patient, physician, social worker, health official, and the public. Particularly sensible are the discussions of genito-infectious diseases in relation to industry, schools, and food-handlers.

It is impossible that all should agree with each detail stated; and certain sections, such as the statistical one on the incidence of these diseases, do little to clarify the issue involved. However, in general, this is a clear and unbiased statement of conditions, avoiding dogmatic statements on controversial issues, but rather presenting all the available evidence and allowing the reader to form his own conclusions.

—From Library of Academy of Medicine.

THE WOMAN'S AUXILIARY

ANNUAL MEETING EXHIBIT, MAY 17-19, 1938



SECTION ON MEDICAL HISTORY



SECTION ON ART

THE EXHIBIT OF THE WOMAN'S AUXILIARY

The exhibit of the Woman's Auxiliary of The Medical Society of New Jersey during the Annual Meeting, May 17, 18 and 19, 1938, was a demonstration of the essential value of the Auxiliary to the medical organization. The place of the Woman's Auxiliary in The Medical Society of New Jersey is shown in the following table of the features of the Annual Meeting:

1. SCIENTIFIC
 Medical and Surgical Sections
 Exhibits
2. ADMINISTRATIVE
 The House of Delegates
 Committee meetings
 Conferences
3. SOCIAL
 Dinners
 Reunions
 Receptions
 Informal sociability
4. CULTURAL
 Medical History
 Authorship—Books
 Art—
 Paintings
 Sculpture
 Photography
 Mementos
 Needlework, etc.

Table of the features of the Annual Meeting

The Woman's Auxiliary can render essential service in the *cultural* aspects of the activities of The Medical Society of New Jersey. Throughout the 173 years of its existence, the Medical Society has emphasized the scientific, the administrative, and the social features of its meetings. The importance of sociability was recognized even in the early days by the Society bearing the expense of dinners at the meetings. Although the Society frequently voted that "Hereafter every member shall pay for his own dinner", the rule was always violated, and the expense was paid out of the Society funds, even to the charge of ten cents for each glass of cider, eight for rum, and three for each Spanish cigar. The good will engendered by the social dinners was as effective as debates and arguments in securing the coöperation of the members.

The founders and the succeeding leaders of The Medical Society of New Jersey were men of culture, and occupied positions of honor and trust in civic affairs. They were members of Congress and State Legislatures, and Judges

of Federal and State Courts; they served on college boards of trustees, and as members of official investigating committees; and they were authors and lecturers on social and welfare subjects, and promoters of hospitals and sanitary measures. The present sanitary measures and welfare movements of New Jersey were promulgated and instituted by physicians acting in the name of The Medical Society of New Jersey.

As the scope of the activities of The Medical Society developed and expanded, the memories of the early leaders were perpetuated in historical and cultural dissertations of which few have been preserved in the archives of the Society. The minutes contain frequent references to collections of official reports and historic relics which were carefully preserved for a time, only to be forgotten and destroyed on the death of the zealous secretaries who collected them. Yet many of these priceless records are still preserved. Historical records, such as those of Cape May, Gloucester, and Camden Counties, and many more, are continually being discovered by members and their wives who are endowed with the cultural instinct.

The cultural aspect of medicine is a field which is peculiarly suited to the *Woman's Auxiliary*, for their members are active in social and education movements, and have the entree to museums and libraries. The historical exhibit of the Auxiliary in 1938 is a prophesy of a quiet expansion of historical research throughout the State.

In August, 1938, the Woman's Auxiliaries to the Counties of Atlantic, Burlington, Camden, and Mercer compiled typed copies of the biographies of some of their leaders, and of their members who became Presidents of The Medical Society of New Jersey. Photographs of these men are also included. These collections of biographies and photographs are invaluable, and are models which other county auxiliaries and medical societies may follow with ease and profit.

Medical history has been adopted as a standard activity of The Medical Society of New Jersey. It was anticipated that a creditable history could be ready for publication by the end of this year; but merely reading the available records and indexing them is still going on. Yet summaries and charts will be available for the exhibit of the Auxiliary, and will demonstrate the wide scope and practical nature of the work when it is completed.

PRESIDENT'S ANNOUNCEMENT

In medicine, as well as in everything else, we can learn from the experiences of those that have gone before. Therefore, I urge all County Presidents to keep in touch with their Medical History and Art Chairmen in order to insure the success of the exhibit at the annual convention. In New Jersey we have untold quantities of material with which to work; let us delve into the project for the benefit of the Medical Society.

MEDICAL HISTORY

It is the desire of the Medical Society that a readable history of each County Medical Society be compiled. Medical history is for the purpose of learning about the personalities of the leaders. Their biographies are best obtained from the County Medical Society of which they are members.

The Auxiliaries of four counties—Atlantic, Burlington, Camden, and Mercer—have collected the biographies and portraits of over 150 medical leaders. These will be displayed in the exhibit next June. This is an example of the kind of practical work which each Auxiliary can do; and an inspiration for it to collect local data for a comprehensive history.

It is little enough to ask the Auxiliary members to demonstrate their usefulness as a liaison agent in helping to collect this data for our Medical Society. Old books, historical documents, relics, and articles pertaining to medical history are all of value for exhibition. It is surprising how much interest and excitement is aroused in the doctors, their families, and guests by the display of art and historical collections of the doctors and their families, especially the data bearing on the medical history of New Jersey.

The exhibition room is a place where you may relax and have all questions answered satisfactorily by our able chairman of the Exhibit of Medical History and Art. We are most fortunate in having Mrs. Beir take the responsibility of this work. She has devoted untold hours to compiling the material in furthering the project for the benefit of the Medical Society and its Auxiliary, and also for the A. M. A. and its Auxiliary.

The Medical History project supplies the Auxiliary with a useful objective which will have universal appeal to all its members.

MRS. DON EPLER, *President*.

COUNTY MEETINGS

Atlantic County

Reported by Mrs. Samuel L. Winn, Publicity Chairman

On January 13th, the *Woman's Auxiliary to the Atlantic County Medical Society* met at the Ambassador Hotel, with Mrs. Andrew Smith presiding, and sixteen members present.

Reports from several committees were heard—By Mrs. Ernest Shore, Public Relations Chairman, we were told of being responsible for placing two speakers before lay groups and also of acquiring the speaker for our open meeting on January 31st.

Our Telephone Committee, headed by Mrs. Stanley McGeehan, has been working untiringly. It contacted each member in reference to the questionnaires, and also in regards to the meeting.

Mrs. Daniel Reyner, of the Public Health Committee, has everything in readiness for the essays which will be read at the February meeting.

The Social Committee has numerous things to be done this month. First, the Reciprocity Tea or open meeting to be held in conjunction with the Women's Club on Tuesday, January 31, 1939, at 2 p. m. at the Crillon Hotel. The speaker for that day will be Dr. Mabel Haines, Audubon, N. J. The topic will be "Mystery of Drugs". Of course we will have music, and tea shall be served after the

meeting. Presidents of all clubs in Atlantic City have been sent invitations, and we hope for either the President or representative to be present from each organization.

On February 14th there will be a public card and game party held at the Ambassador Hotel—Surf Room. Representatives from sister counties in the State are cordially invited.

Dr. John Bucher, F.R.G.S., was the speaker of the month. His topic was "An Observer Looks at Europe".

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at the Ambassador Hotel, Friday evening, February 10th, 1939.

Our Social Committee Chairman, Mrs. Whims, stressed attendance and coöperation and announced that a Valentine card party will be held February 14th at the Ambassador Hotel, the proceeds of which will be put into our treasury.

The winners of the school contest for the best essay on the subject "What to Eat to Keep Well" were present as our guests. LeRoy Mattson, from the Absecon Public Schools, won the first prize of \$10.00; Laura Giberson, Egg Harbor Township, \$5.00, and Walter Bailey, of the Atlantic City Junior

High School, \$3.00. Honorably mentioned were James Hewitt, Ventnor Avenue School; Dora Resh, of Egg Harbor Township, and Jane Hardy, also of Egg Harbor Township. These received pen and pencil sets.

Mrs. Daniel Reyner, who took care of all details of the contest, awarded the honors.

There were twenty-four members present, three guests, and five children.

Camden County

Reported by Mrs. George B. German

The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held Tuesday, January 17th, 1939, at the home of Mrs. H. Wesley Jack, President, of Haddonfield, with fifty-two members present.

The program of the meeting included three book reviews. Mrs. Raul Betancourt, of Moorestown, discussed "The Horse and Buggy Doctor", by Arthur Hertzler, M.D.; and Mrs. Oswald Carlander, of Merchantville, spoke on "Dr. Nye of North Ostable", by Joseph C. Lincoln. Mrs. Max Weiman, of Haddon Heights, gave an excellent review of "Madame Curie", a biography by her daughter, Eve Curie.

Mrs. Edward C. Pechin, of Haddonfield, and Mrs. George B. German, of Merchantville, poured at the tea which followed the meeting. Mrs. O. W. Saunders, of Camden, who is chairman of the Hospitality Committee, was assisted by Mrs. Vincent P. McDermott, Mrs. Banks Baker, Mrs. Edwin Murray, and Mrs. Kenneth Athey, all of Camden, and Mrs. Kenneth B. McAlpine, of Gloucester.

Essex County

Reported by Mrs. Frank S. Forte

The monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on Monday, January 23rd, 1939, with Mrs. Gustave A. Braun presiding.

Mrs. Francis Kerns, Program-Health Education Chairman, introduced the guest speaker, Dr. Rita A. Finkler, an endocrinologist, who discussed obesity as it is influenced by glandular conditions, pointing out that faulty functioning of certain glands produces excessive stoutness.

Satisfactory reports were received from the various chairmen.

It was voted at this meeting to have the meetings monthly instead of quarterly.

Mrs. Don A. Epler, Membership Chairman, reported six new members since last meeting; Mrs. Peter Motzenbecher, Mrs. John B. Casale, Mrs. Royal A. Schaaf, Mrs. Raymond Mullin and Mrs. Leonard S. Greenfield, of Newark, and Mrs. Jacob Schmuchler, of Maplewood.

A tea followed the meeting. Mrs. Gustave A. Braun, President, and Mrs. Don Epler, President of the State Auxiliary, poured. Mrs. Theodore Glazier, Hospitality Chairman, was in charge of the tea.

Gloucester County

Reported by Mrs. Paul Pegau, Publicity Chairman

The *Woman's Auxiliary to the Gloucester County Medical Society* held a Colonial Tea at the home of Mrs. Ralph Venturo, Glassboro, N. J., Thursday, February 16th, 1939. A large number of members and guests were present to hear a most delightful program arranged by the committee in charge. The President of the Woman's Auxiliary to the State Medical Society, Mrs. Don Epler, was guest of honor, and was introduced by Mrs. Fred Wandall, President of the Woman's Auxiliary to the Gloucester County Medical Society. Guests sharing the program were Mr. Harry Tipping, noted radio singer; Mrs. Fred Gravino, accomplished pianist; and Mrs. Guernsey Sholl, a most pleasing reader.

The committee in charge were: Mrs. Ralph Venturo, Mrs. L. K. Collins, Mrs. William Pedrick, Mrs. I. W. Knight, and Mrs. Fred Wandall.

Hudson County

Reported by Nellie D. Nevin

The regular meeting of the *Woman's Auxiliary to the Hudson County Medical Society* took place on February 5th with Mrs. E. J. Chapman presiding in the absence of Mrs. Charles B. Kelley.

Satisfactory reports of all activities were given by the chairmen.

Dr. Harry J. Perlberg, head of the X-Ray Department of the Jersey City Medical Center, was the guest speaker, and gave a comprehensive history of the x-ray since its discovery in 1893, telling of its growth and value, and its universal aid in the world of medicine and surgery.

Resignations of Mrs. Harold Hoops and Mrs. M. F. Barry, both of whom have moved from Hudson County, were accepted.

Mercer County

Reported by Mrs. Catherine Chianese

The *Woman's Auxiliary to the Mercer County Medical Society* held its first Fall meeting at the Nurses' Residence of Saint Francis Hospital on Monday, October 24, 1938, at 2 p.m., with Mrs. Edmund W. Burroughs, President, presiding.

Officers for the year 1938-1939 are as follows:

President, Mrs. Edmund W. Burroughs
President-Elect, Mrs. Frank A. McGuigan
First Vice-President, Mrs. James J. McGuire
Second Vice-President, Mrs. A. Dunbar Hutchinson
Secretary, Mrs. Maurice Zentner
Treasurer, Mrs. Paul Klempner

The following committee chairmen were appointed:

Arrangements, Mrs. William C. Ivins
Art, Hobby, Medical History, Mrs. H. Donald Cowlbeck
Historian, Mrs. George N. J. Sommer
Public Relations, Mrs. D. Leo Haggerty
Health Program, Mrs. Robert J. Cottone
Scrap Book, Mrs. George A. Corio
Entertainment, Mrs. James R. Harman

Membership Committee—

Mrs. John F. Kustrup, St. Francis' Hospital
Mrs. A. W. Belting, McKinley Hospital
Mrs. C. Chester Chlanese, Mercer Hospital

Miss Janet MacKenzie has been selected by the Student Nurse Scholarship Committee to receive the full scholarship award, which will cover three years in the Mercer Hospital Training School for Nurses.

Surgical dressings were folded during the afternoon.

A social half-hour was enjoyed, during which tea was served by the Sisters of the hospital, with Mrs. J. F. Kustrup as hostess.

The Woman's Auxiliary met at the Nurses' Residence of Mercer Hospital on Monday, November 14th, 1938, with Mrs. Edmund W. Burroughs, President, presiding.

Surgical dressings were made throughout the day.

At one o'clock a luncheon was served, with Mrs. C. Chester Chlanese as hostess.

A short business session was conducted by the President, during which plans were furthered for the luncheon-bridge. Tickets were distributed by the committee in charge.

Mrs. Patrick H. Corrigan introduced the speaker for the day,—Mr. Louis Altman,—who gave an interesting and amusing talk on the Dale Carnegie Course in Public Speaking.

The *Woman's Auxiliary to the Mercer County Medical Society* held a luncheon-bridge on Saturday afternoon, December 3rd, 1938, at Fischer's Tea Room at Washington's Crossing. Over fifty tables were in play with prizes at each table.

The committee assisting Mrs. James R. Harman, committee chairman, were Mrs. W. C. Ivins, Mrs. E. B. Bearisto, Mrs. J. R. O'Rourke, Mrs. P. Finegan and Mrs. J. L. Wikoff.

This party was very successful both socially and financially. Profits realized are to be added to the Benevolent Fund.

Passaic County

Reported by Mrs. Joseph E. Mott

Thirty-nine members of the *Woman's Auxiliary to the Passaic County Medical Society* were the guests of their President, Mrs. William Spickers, at her Franklin Lake residence on Monday, January 16.

Mrs. Theodore K. Graham reported on the accession of two new members.

Mrs. T. Rothman reported on the excellent response of lay organizations to health lectures given by speakers sent by the Auxiliary.

Mrs. A. Shulman reviewed "The Horse and Buggy Doctor".

Selections from *LaBoheme* were sung by Miss Helen Renstrom.

Somerset County

Mrs. C. F. Halsted, Reporter

The regular meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held February 9, 1939, with Mrs. E. T. Flint presiding, and five members present.

Reports were received from the Secretary, Mrs. C. F. Halsted, and the Treasurer, Mrs. J. L. Young.

The program consisted of talks on hobbies by members, and concluded with a social hour.

Union County

Reported by Mrs. Herschel S. Murphy

On Wednesday evening, September 21, the *Woman's Auxiliary to the Union County Medical Society* held its first meeting of the year, at the home of Dr. and Mrs. E. W. Lance, of Rahway. The program, which was to have been a talk by Dr. Norman W. Burritt, was postponed on account of the bad storm. A short business meeting was conducted by Mrs. D. R. McElhinney, President, to outline our year's work. Plans for a supper dance were tentatively discussed, naming Mrs. George Knauer, of Elizabeth, Chairman.

Those present were Mrs. D. R. McElhinney, Mrs. George Knauer, Mrs. G. A. Seymour, Mrs. Victor du Busc, of Elizabeth; Mrs. E. W. Lance, Mrs. C. F. Card, of Rahway; Mrs. F. J. De Cesare, of Roselle Park; Mrs. H. S. Murphy, of Roselle.

At the close of the meeting refreshments were served. Mrs. McElhinney poured; Mrs. Lance, Mrs. Knauer and Mrs. Murphy assisted.

Warren County

Reported by Mrs. W. H. Varney, Publicity
Chairman

The *Woman's Auxiliary to the Warren County Medical Society* held its first Fall meeting at the Hotel Belvidere in Belvidere, New Jersey, on October 18, 1938. Six members were present. Since there was no business to discuss, a social hour was enjoyed, after which they joined the doctors for lunch.

On November 15th, Mrs. F. J. LaRiew, Washington, N. J., entertained seven members of the Auxiliary. After a short business meeting, tea was served by the hostess.

There was no meeting in December. The *Woman's Auxiliary* will have its next meeting at the Elks' Club in Phillipsburg, and after a business session will join the doctors for lunch.



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FINKELMAN, I. AND SHAPIRO, L. B.: Benzedrine Sulfate and Atropine in Treatment of Chronic Encephalitis—*J. A. M. A.*, 109:344, July 31, 1937.

DAVIS, P. L. AND STEWART, W. B.: The Use of Benzedrine Sulfate in Postencephalitic Parkinsonism, *J. A. M. A.*, 110:1890, June 4, 1938.

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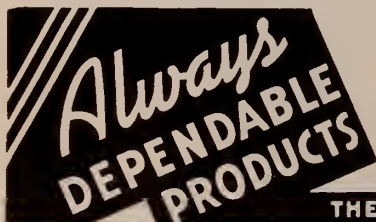
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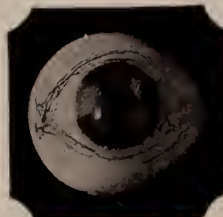
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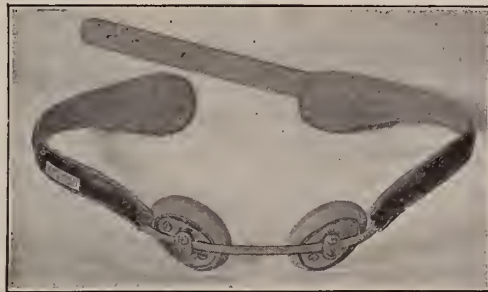


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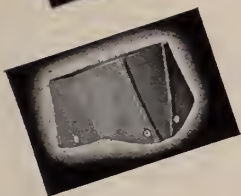
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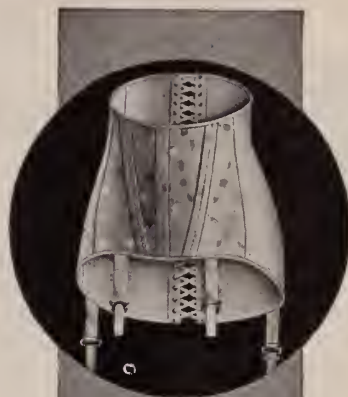


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THE 173rd ANNUAL MEETING IN HADDON HALL,
ATLANTIC CITY, JUNE 6, 7, AND 8, 1939

THE JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorial and Executive Offices of the Society
143 EAST STATE STREET, TRENTON, N. J. TEL. 9330

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Founded July 23, 1766

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THE MEDICAL SOCIETY OF NEW JERSEY

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BEGINNING MAY 19, 1938

WILLIAM J. CARRINGTON, Atlantic City, President and Ex-Officio Member of Each
Committee —By-Laws, Chapt. VI, Sect. 1

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WILLIAM HENRY VARNEY, *Vice-Chairman* Washington
EDWIN GRAFING DEWIS Interlaken
ROBERT MARTIN GRIER Pleasantville
EDWARD CAFFRON KLEIN Newark
AUGUSTUS S. KNIGHT Far Hills
ADOLPH TOWBIN Lakewood
WATSON BUDLONG MORRIS, *Consultant* Springfield

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Annual Meeting

CHARLES BUTCHER KAIGHN, *Chairman* Atlantic City
CLARENCE LADELLE ANDREWS, *Chairman, Sub-Com. on Scientific Program* Atlantic City
ASHER YAGUDA, *Chairman, Sub-Com. on Scientific Exhibits* Newark
THOMAS MCGRATH BRENNOCK Jersey City
JOHN CLIFFORD CLARK Asbury Park
WILLIAM JOHN CARRINGTON, *Consultant* Atlantic City

Meetings

Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Auxiliary Medical Service

WILLIAM WALLACE MAVER, *Chairman* Jersey City
SAMUEL BARBASH, *Vice-Chairman* Atlantic City
ARTURO RAYMOND CASILLI Elizabeth
EUGENE GARFIELD HERBENER Lakewood
SIGURD WALTER JOHNSEN Passaic
JEROME HOWARD SAMUEL Newark
WALTER ALBERT TAYLOR Trenton
ALFRED STAHL, *Consultant* Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Cancer Control

WILLIAM GETTIER HERRMAN, *Chairman* Asbury Park
HENRY BOYLAN ORTON, *Vice-Chairman* Newark
HAROLD STERN DAVIDSON Atlantic City
ELLWOOD EMERSON DOWNS Woodbury
JOHN BUTLER FAISON Jersey City
OTTO RUDOLPH HOLTERS Asbury Park
JOSEPH HENRY KLER New Brunswick
AUGUSTUS S. KNIGHT Far Hills
CHARLES B. WOODMAN Morristown
THOMAS BENJAMIN LEE, *Consultant* Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Child Health

STANLEY NICHOLS, *Chairman* Long Branch
WALTER BLAIR STEWART, *Vice-Chairman* Atlantic City
ARTHUR FOWLER ACKERMAN Summit
CHESTER BROWN Arlington
ERNEST GARFIELD HUMMEL Camden
IRVING OKIN Passaic
LOUIS CHARLES ROSENBERG Newark
ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Constitution and By-Laws

JAMES FRANCIS NORTON, *Chairman* Jersey City
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GEORGE N. J. SOMMER Trenton
DAVID H. BARTINE ULMER Moorestown
FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.

Contract Practice

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JENNINGS HOWARD HORNBERGER, *Consultant* Roebling
ANDREW C. RUOFF Union City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Crippled Children

BABCLAY WELLINGTON MOFFAT, *Chairman* Red Bank
ELMER PETER WEIGEL, *Vice-Chairman* Plainfield
OSWALD RUDOLPH CARLANDER Camden
FREDERICK GEORGE DILGER Hackensack
WILLIAM GREENFIELD Hackensack
EMANUEL HARRISON NICKMAN Atlantic City
TOUFFICK NICOLA Montclair
HERBERT WILLIAM NAFEY, *Consultant* New Brunswick

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Finance and Budget

HARRY ROSS NORTH, *Chairman* (1939)Trenton
HERSCHEL PETTIT (1942)Ocean City
WELLS PHILLIPS EAGLETON (1943)Newark
ANDREW FRANCIS MCBRIDE (1941)Paterson
DAVID B. ALLMAN (1944)Atlantic City
HENRY SPENCE (1940)Jersey City
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*EPHRAIM ROLAND MULFORDBurlington
FREDERIC JAMES QUIGLEYUnion City
No meetings, work carried on by correspondence.

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HENRY BRISTOL DECKERCamden
FLORENTINE MILTON HOFFMANNew Brunswick
CHARLES HYMANAtlantic City
ELTON WALLACE LANCERahway
GEORGE O'HANLONJersey City
THOMAS KRAPPFEL LEWIS, *Consultant*Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Industrial Injuries and Occupational Diseases

J. IRVING FORT, *Chairman*Newark
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CHARLES LITWINTeaneck
TRAUGOTT JOHN SCHUCKHoboken
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Commissioner J. J. Toohey, N. J. Dept. of Labor. Newark
ROY GRIFFITH, *Technical Adviser*, representing the Manu-
facturers' Association of New JerseyGlen Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Legislation

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WILLIAM CRANE WILENTZPerth Amboy
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
Others at call of Chairman

Maternal Welfare

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JOHN CARLISLE BROWN, *Vice-Chairman*Atlantic City
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GEORGE BURTON GERMANCamden
CARL HALLER ILLNewark
JULIUS LEVYNewark
ROBERT ABBE MACKENZIEAsbury Park
WALTER BARCLAY MOUNTMontclair
JAMES HARRIS UNDERWOODWoodbury
HARRISON BETTS WILSONHackensack
THOMAS BENJAMIN LEE, *Consultant*Camden

Meetings

Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
January, 1939, Joint Meeting with County Ma-
ternal Committees and Field Physicians; date,
hour, and place to be selected by Chairman,
Dr. Bingham.

Medical Care of Indigent and Low-Wage Group

GEORGE WASHINGTON FITHIAN, *Chairman*Perth Amboy
DAVID WRIGHT GREEN, *Vice-Chairman*Salem
FRANK L. FIELDFar Hills
DANIEL LEO HAGGERTYTrenton
WARREN DAVID ROBBINSCape May
BYRON GRANT SHERMANMorristown
EDWARD MATHIAS ZEE HAWKES, *Consultant*Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Medical Defense and Insurance

CHRISTOPHER CHARLES BELING, *Chairman*Newark
JOSEPH WALLACE HURFF, *Vice-Chairman*Newark
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GEORGE THOMAS TRACYBeverly
WILLIAM CARTER WESCOTTAtlantic City
WELLS PHILLIPS EAGLETON, *Consultant*Newark

Meetings

Atlantic City...May 19, 1938.....4 p. m.
Interim meetings at the call of Chairman
Trenton.....Apr. 16, 1939.....4 p. m.

Medical Practice

DAVID BACHARACH ALLMAN, *Chairman*Atlantic City
SPENCER TREADWELL SNEDECOR, *Vice-Chairman*Hackensack
HARRY NOAH COMANDONewark
GEORGE WASHINGTON FITHIANPerth Amboy
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WILLIAM WALLACE MAVERJersey City
REUBEN LORE SHARPCamden
CHESTER ISAAC ULMERGibbstown
ANTHONY CHARLES ZEENDERNewark
THOMAS KRAPPFEL LEWIS, *Consultant*Camden

Meetings

Atlantic City...May 19, 1938.....4 p. m.
Trenton.....Apr. 16, 1939.....4 p. m.
For meeting of Advisory Committees see their
schedules

Mental Hygiene

JAMES STUART PLANT, *Chairman*Newark
MARCUS ALBERT CURRY, *Vice-Chairman*Greystone Park
WILLIAM COLE DAVISAtlantic City
BARCLAY STOKES FUHRMANNFlemington
ALLEN GILBERT IRELANDTrenton
EDWARD SHEAFE KRANSPlainfield
CLARENCE MORTON TRIPPEAsbury Park
HERBERT WILLIAM NAFEE, *Consultant*New Brunswick
AMBROSE DOWD, *Technical Adviser*, representing Commis-
sioner Ellis, N. J. Department of Institutions and
AgenciesNewark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
One or two other meetings at call of Chairman

Nursing and Nursing Education

ANTHONY CHARLES ZEENDER, *Chairman*Newark
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VICTOR KNAPPAsbury Park
FRANK LESLIE PERRYWoodstown
HARRY SUBINAtlantic City
THOMAS J. FRANCIS WALSHElizabeth
WELLS PHILLIPS EAGLETON, *Consultant*Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

* Deceased.

Pharmaceutical Problems

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CHARLES JOSEPH MURN	Paterson
DANIEL WOOLSEY TELLER, JR.	Morristown
RALPH KING HOLLINSHED, <i>Consultant</i>	Westville

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Pneumonia Control

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HENRY PAUL DENGLE	Springfield
*MARSHALL FLOWER LUMNIS	Pitman
FREDERICK THOMAS VOSBURGH	Passaic
RALPH KING HOLLINSHED, <i>Consultant</i>	Westville
WILLIAM MACDONALD, <i>Technical Adviser</i> , representing Dr. J. Lynn Mahaffey, Director N. J. Department of Health	Trenton

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Post-Graduate Education

DAVID FULLER BENTLEY, <i>Chairman</i>	Haddonfield
STUART ZEH HAWKES, <i>Vice-Chairman</i>	Newark
ALBERT WILLIAM PICOTT	Skillman
ERNEST FRANCIS PURCELL	Trenton
HAMMELL PIERCE SHIPPS	Delanco
SLOAN GRIFFIN STEWART	Atlantic City
CLARENCE WILTON WAY	Sea Isle City
HARRY ROSS NORTH, <i>Consultant</i>	Trenton

Meetings

Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.

Public Health

STANLEY NICHOLS, <i>Chairman</i>	Long Branch
FREDERIC WILLIAM LATHROP, <i>Vice-Chairman</i>	Plainfield
FRANK A. BIEN	Irvington
ARTHUR WALTER BINGHAM	East Orange
CHARLES BYRON BLAISDELL	Long Branch
JACOB IRVING FORT	Newark
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ALLEN GILBERT IRELAND	Trenton
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JULIUS LEVY	Newark
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ELLEN POTTER and EMIL FRANKEL, representing Wm. G. Ellis, N. J. Dept. Institutions and Agencies.	
HENRY HOWARD KESSLER, representing J. J. Toohey, N. J. Dept. of Labor.	
WILLIAM MACDONALD, representing Director Mahaffey, N. J. Dept. of Health.	
HOWARD DARE WHITE, representing Director Elliott, N. J. Dept. of Public Instruction.	

Meetings

Long Branch.....	July 10, 1938.....	3 p. m.
Newark.....	Sept. 7, 1938.....	3 p. m.
Newark.....	Oct. 5, 1938.....	3 p. m.
Newark.....	Nov. 2, 1938.....	3 p. m.
Newark.....	Dec. 7, 1938.....	3 p. m.
Newark.....	Jan. 4, 1939.....	3 p. m.
Newark.....	Feb. 1, 1939.....	3 p. m.
Newark.....	Mar. 1, 1939.....	3 p. m.
Newark.....	Apr. 5, 1939.....	3 p. m.
Newark.....	May 3, 1939.....	3 p. m.

*Deceased.

Public Relations

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JACOB ALLEN YAGER	Paterson
ELIAS JOSEPH MARSH, <i>Consultant</i>	Paterson

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Publication

HENRY C. BARKHORN, <i>Chairman</i> (1939)	Newark
EDWARD J. ILL (1940)	Newark
JAMES LAWRENCE EVANS (1941)	North Bergen
WILLIAM JOHN CARRINGTON, Ex-Officio	Atlantic City
ALFRED STAHL, Ex-Officio	Newark
FRANK OVERTON, Editor	Trenton

Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Newark.....	July 27, 1938.....	4:30 p. m.
Newark.....	Aug. 31, 1938.....	4:30 p. m.
Newark.....	Sept. 28, 1938.....	4:30 p. m.
Newark.....	Oct. 26, 1938.....	4:30 p. m.
Newark.....	Nov. 23, 1938.....	4:30 p. m.
Newark.....	Dec. 28, 1938.....	4:30 p. m.
Newark.....	Jan. 25, 1939.....	4:30 p. m.
Newark.....	Feb. 22, 1939.....	4:30 p. m.
Newark.....	Mar. 29, 1939.....	4:30 p. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Scientific Exhibits

ASHER YAGUDA, <i>Chairman</i>	Newark
JAMES GORDON BOYES, <i>Vice-Chairman</i>	Plainfield
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WILLIAM WOLF HERSOHN	Atlantic City
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Meetings

Trenton.....	Aug. 7, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Scientific Program

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HARRISON STANFORD MARTLAND	Newark
PAUL BRYSON REISINGER	Trenton
WILLIAM JOHN CARRINGTON, <i>Consultant</i>	Atlantic City

Meetings

Trenton.....	Aug. 7, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

Study of Sterilization

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WALTER JOHN FARR	Teaneck
THEODORE RUSSELL ROBIE	East Orange
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Meetings

Trenton.....	June 5, 1938.....	11 a. m.
Trenton.....	Oct. 2, 1938.....	11 a. m.
Trenton.....	Dec. 4, 1938.....	11 a. m.
Trenton.....	Feb. 19, 1939.....	11 a. m.
Trenton.....	Apr. 16, 1939.....	11 a. m.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XII

April, 1939

No. 4

THE slogan of this year's Early Diagnosis Campaign is "Help Find Early Tuberculosis." The sub-slogan "8 out of 10 who come to the sanatorium are advanced cases" is based on national statistics which show that only about 20% of sanatorium admissions are classified as minimal cases. The classification is not an arbitrary one but conforms with standards agreed upon by eminent tuberculosis specialists. Every practitioner should be familiar with the terms "Minimal, moderately advanced and far advanced." They are defined in "Diagnostic Standards—Tuberculosis of the Lungs and Related Lymph Nodes" published by the National Tuberculosis Association. The most recent edition, 1938, brings the standards into line with current thought. The three stages of pulmonary tuberculosis are defined as follows:

Extent of Pulmonary Lesions

Minimal

Slight lesions without demonstrable excavation confined to a small part of one or both lungs. The total extent of the lesions, regardless of distribution, shall not exceed the equivalent of the volume of lung tissue which lies above the second chondrosternal junction and the spine of the fourth or body of the fifth thoracic vertebra on one side.

Moderately Advanced

One or both lungs may be involved, but the total extent of the lesions shall not exceed the following limits:

- a. Slight disseminated lesions which may extend through not more than the volume of one lung, or the equivalent of this in both lungs.
- b. Dense and confluent lesions which may extend through not more than the equivalent of one-third the volume of one lung.
- c. Any gradation within the above limits.
- d. Total diameter of cavities, if present, estimated not to exceed 4 cm.

Far Advanced

Lesions more extensive than Moderately Advanced.

Single copies of Diagnostic Standards may be obtained *free* from your tuberculosis association or the National Tuberculosis Association.

Symptoms

None.

Slight. Constitutional and functional symptoms, such as loss of weight, ease of fatigue, and anorexia are slight and not rapidly progressive. Temperature not more than one-half degree above normal at any time during the twenty-four hours. Slight or moderate tachycardia. Cough, if any, is not hard or continuous; sputum, if any, may amount to one ounce or less in twenty-four hours.

Moderate. Symptoms of only moderate severity; fever, if any, does not exceed two degrees. No marked impairment of function, either local or constitutional, such as marked weakness, dyspnea and tachycardia. Sputum usually does not exceed three or four ounces in twenty-four hours.

Severe. Marked impairment of function, local or constitutional. Usually there are profound constitutional symptoms, such as weakness and continuous or recurrent fever. Cough often is hard and distressing and the sputum may be copious.

STAGE OF DISEASE INFLUENCES PROGNOSIS

Hilleboe succeeded in tracing 92.7% of more than 5,000 patients discharged from 10 of the 15 public tuberculosis sanatoria in Minnesota during the ten-year period 1926-1935. Patients studied were about equally divided between rural and urban residents. Of the total number about 36% were dead on discharge. This tremendous loss gives some measure of the tragic toll taken by this disease even during hospitalization when expert medical attention and every facility for treatment are available. Living and dead are classified, according to stage of disease, as shown approximately in Chart I.

DISCHARGED PATIENTS

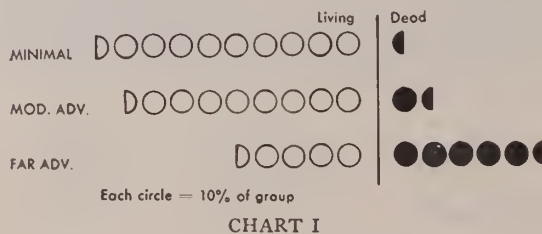


CHART I

Stage of disease influences the length of time needed for recovery. In this study all patients were in the sanatorium for 90 days or more. Living patients, not including those who were admitted more than once were classified according to the average length of stay in the sanatorium and the stage of the disease. Chart II pictures roughly the result.

LENGTH OF STAY IN SANATORIUM

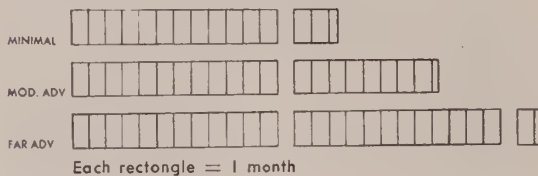


CHART II

The influence of stage of disease on the condition at the time of discharge was studied and the results confirmed the observation that the early case has a much better chance of satisfactory recovery than the advanced case. The result is summarized in Chart III.

CONDITION ON DISCHARGE

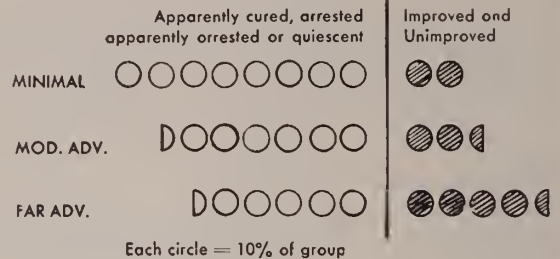


CHART III

The probabilities of dying from any given disease can be calculated by actuaries with a fair degree of accuracy. In a person with tuberculosis the risk of dying is increased and this risk is in direct ratio to the stage of disease as shown in Chart IV.

RISK OF DYING INCREASED BY TUBERCULOSIS

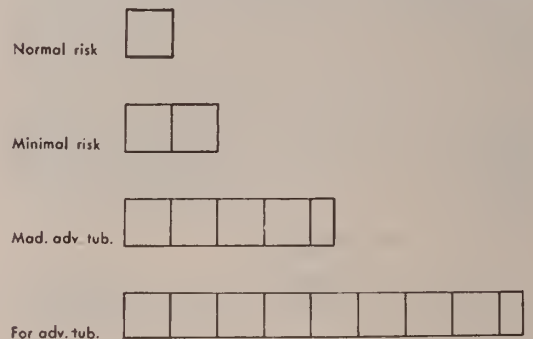


CHART IV

"Statistical study of comparative mortality in discharged patients gives valid proof of the soundness of many clinical concepts regarding the disease. After all, one of the real values of statistics is to confirm the impressions of sound clinicians. Beneficial effects of early diagnosis of serious pulmonary tuberculosis lesions are reflected in the smaller risk of dying on the part of the minimal cases in comparison with the more advanced cases during the dangerous first five years after discharge. Tuberculosis must be diagnosed early."

Follow-up Study of Patients Discharged From Tuberculosis Sanatoria. H. E. Hilleboe, M.D., Transactions of the Thirty-fourth Annual Meeting of the National Tuberculosis Association, 1938.

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Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Tuberculosis

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Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Venereal Disease Control

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WILLIAM FRANCIS COSTELLO, *Consultant* Dover
ARTHUR JAY CASSELMAN, *Technical Adviser*, representing Dr. Jesse Lynn Mahaffey, Director of N. J. Dept. of Health Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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CHARLES BYRON BLAISDELL Long Branch
WENDALL JONES BURKETT Pitman
NORMAN WYVELL BURRITT Summit
EDGAR PARMELE CARDWELL Newark
HARRY NOAH COMANDO Newark
MARCUS ALBERT CURRY Greystone Park
WALTER JOHN FARR Teaneck
FRANK L. FIELD Far Hills
GEORGE WASHINGTON FITHIAN Perth Amboy
JACOB IRVING FORT Newark
BARCLAY STOKES FUHRMANN Flemington
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HERRMAN, WILLIAM GETTIER, representing the M. S. of N. J. on the Board of Trustees of the Hospital Service Plan of N. J.
* Deceased.

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Meetings

Trenton.....June 5, 1938.....1 p. m.
Trenton.....Oct. 2, 1938.....1 p. m.
Trenton.....Dec. 4, 1938.....1 p. m.
Trenton.....Feb. 19, 1939.....1 p. m.
Trenton.....Apr. 16, 1939.....1 p. m.

Woman's Auxillary

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JOSEPH ROWLETT MORROW Ridgewood
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Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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V. EARL JOHNSON Atlantic City
HENRY HOWARD KESSLER Newark
CEDRIC C. CARPENTER Summit
FREDERICK WILLIAM SHAFER Camden
DANIEL F. FEATHERSTON Asbury Park
ANDREW FRANCIS MCBRIDE, *Consultant* Paterson
STEPHEN J. LORENZ, *Technical Adviser*, representing J. J. Toohy, N. J. Dept. of Labor Trenton
ROY GRIFFITH, *Technical Adviser*, representing the Manufacturers' Association of N. J. Glen Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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UNION	Henri E. Abel, Elizaheth	Lorrimer B. Armstrong, Westfield.	R. J. Walsh, Roselle
WARREN	Clyde Smith, Oxford	William F. Skinner, Washington..	H. B. Bossard, Phillipsburg

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CAMDEN	Edmund Hessert	Collingswood	607
CAPE MAY	Clarence W. Way	Sea Isle City	55
CUMBERLAND	J. S. Knowles	Millville	52
ESSEX	Alfred Muerlin	158 S. Harrison St., East Orange	Orange 5-9026
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HUDSON	Joseph P. Donnelly	1 Madison Ave., Jersey City	Delaware 3-6682
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MONMOUTH	William Heatley	Red Bank	80
MORRIS	George L. Nicoll	Dover	180
OCEAN	George W. Gaumer	422 First St., Lakewood	81
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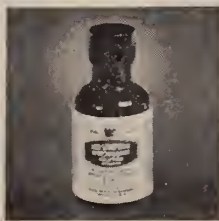
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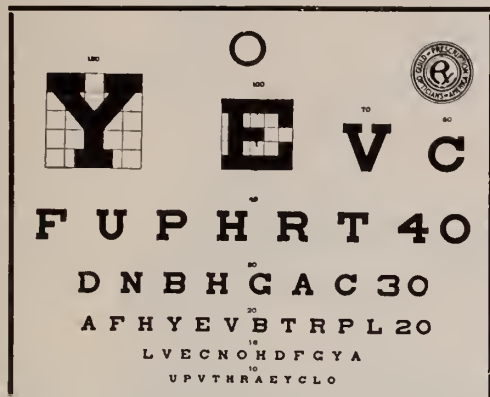
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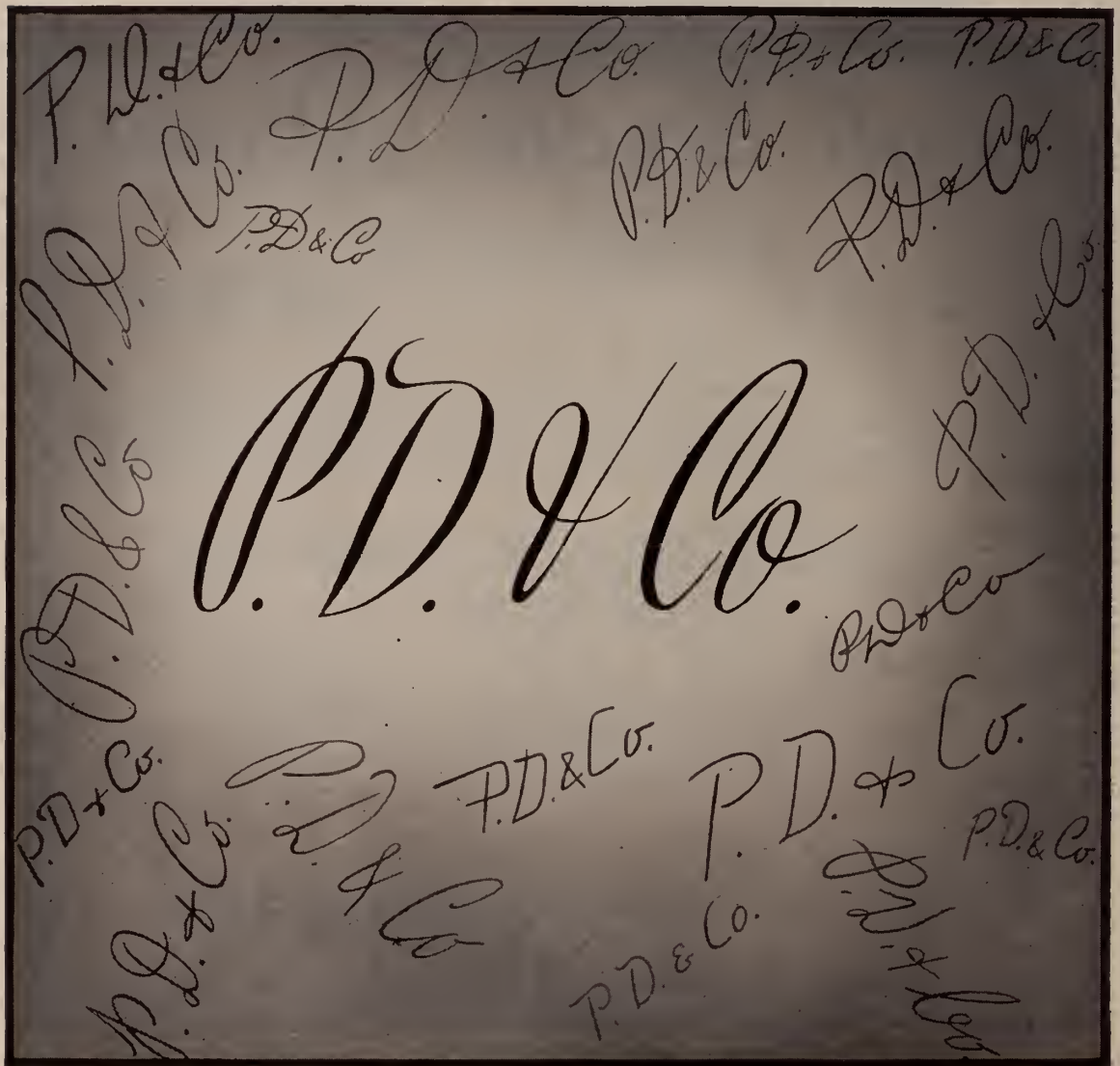
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- (1) 1937. Am. J. Digestive Diseases,
Nutr. 4, 240.
(2)a. 1933 J. Am. Diet. Assn. 9, 295.
b. 1934. J. Nutrition 8, 449.

- (2)c 1936. Ibid. 12, 405.
d. 1936. J. Am. Diet. Assn. 12, 231.
(3) 1932. J. Pediatrics 1, 749.
(4) 1938. Am. J. Diseases Children 55, 1158.

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*Sherman, H. C., *Chemistry of Food & Nutrition*, pages 69-71, inclusive



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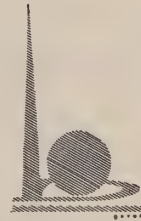
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NEWARK	Ewald Broch, 398 Central Ave.	MArket 2-0839
EAST ORANGE	Freitag-Gillbard Drug Store, 331 Main St.	ORange 5-9639
CALDWELL	Herman Hasler, 295 Bloomfield Ave.	CALdwell 6-0003
VERONA	Moellering's Pharmacy, Bloomfield & Grove Aves.	VERona 8-5401
MAPLEWOOD	Leo F. Feindt, Valley St. at Parker Ave.	South Orange 2-2425
BELLEVILLE	Capitol Pharmacy, 338 Washington Ave.	BELleville 2-1521
UPPER MONTCLAIR	Linn's Pharm., 107 Watchung Ave.	MONTclair 2-1692
ORANGE	Rinck's Pharmacy, 625 Scotland Rd.	ORange 5-8247
ROSELLE	Butler Pharmacy, 206 Chestnut St.	ROsell 4-1700
PLAINFIELD	The Richmond Pharmacy, 209 Richmond St.	PLainfield 6-5312
WESTFIELD	Russel E. Darby, Inc., 339 So. Ave. W.	WEStfield 2-1198
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY

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COMMITTEE ON PUBLICATION



EDITOR OF
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FRANK OVERTON, M.D., Dr. P.H.

Editorial and Executive Offices of the Society—143 East State Street, Trenton, N. J.; Tel. 9330

EXECUTIVE OFFICER—LEROY A. WILKES, M.D.
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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. XXXVI, No. 4

APRIL, 1939

Subscriptions, \$3.00 per Year
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EDITORIALS

Discussions at the Annual Meeting

The May issue of the Journal will be the most important one of the whole year,—for in it the officers and committeemen will tell what they have done during the past year, and will point out desirable lines of work for next year.

Discussing the reports and acting upon them will occupy three-fourths of the time of the sessions of the House of Delegates, which will hold its meetings on June 6, 7, and 8, 1939. But as a matter of fact the Annual Meeting really opened in the middle of March when each officer and chairman began to give serious thought to the form and the content of his report. The day of the formal essay has passed, as has also the rambling address given impromptu and without preparation. The reports of today are designed to be read and studied by every member of the Society a month before the meeting. They are not even spoken to the Delegates, but are referred to reference committees at the very opening of the annual session in order to give every Delegate or member of the Society an opportunity to present his argument either for or against any feature of the report, in an informal way.

Much more can be accomplished by an informal talk in the privacy of the committee room, than by a formal address before the whole body of Delegates, who would be bored rather than enlightened by long arguments on trivial points and personalities. After all, what an objector wishes is the opportunity to express his private opinions in his own manner.

After members of a reference committee have considered a report for a month previous to the meeting, and possibly for several hours during the course of the meeting, they are usually ready to give an opinion that is judicial, and is satisfactory to all the members. At any rate the great majority of the Delegates remain throughout every session and maintain a keen interest in all the proceedings.

Finally, no matter what the decision of a reference committee may be, the members are assured that every debatable point has received careful consideration; and in case of a division of opinion, about all that remains to be done on the floor of the house is to take a vote on the question.

Composition of the House of Delegates

The executive work of The Medical Society of New Jersey is done by its officers and committees; but the authorization of the scope of the activities and the allocation of funds lies with the House of Delegates, which is the supreme legislative body of the Society. An analysis of the membership of these two groups will demonstrate that a surprising large proportion of the membership of the State Society takes an active part in the management of its affairs. The following figures demonstrate this fact.

OFFICERS AND COMMITTEES

The number of individual members who served as officers and committeemen during the past year was 212, as is shown by the list of members that was printed on advertising pages III-XII of the Journal of June, 1938. The number was actually larger later in the year because new committees were set up.

DELEGATES AND ALTERNATES

The membership of the House of Delegates printed on the program of the Annual Meeting of 1938 was as follows:

Delegates <i>not</i> officers or committeemen (one to every 15 members of the county societies)	172
Delegates who were officers or committeemen	59
Total	231

Alternates who were <i>not</i> officers or committeemen	189
Alternates who were officers or committeemen	24
Total	203
Total membership of the House of Delegates (Delegates and Alternates)	434

Percentage of the House of Delegates who were <i>not</i> officers or committeemen	83%
Delegates who were Fellows, officers, or committeemen	17%

Number of Fellows, officers and committeemen listed in the June Journal	212
Number serving as Delegates or Alternates ..	83
Percentage	40%
Total number of members on the Official List of 1938	3484
Total number of individual members serving as Fellows, officers, Delegates, and Alternates	573
Percentage	16%

A SOCIETY AT WORK

These figures demonstrate that The Medical Society of New Jersey is a *Society at Work*; and that the largest group of members of its governing body are those who are elected by vote of the county societies.

It is an accepted fact that the elected Delegates and Alternates are chosen from among the members who are the most active in their county societies.

Editing the Annual Reports

The scientific department of the May Journal will be on the subject of "Administrative Medicine"; and will consist of the carefully planned reports of the officers and committees. Last year thirty-seven reports were printed, filling sixty-two pages of the Journal—a number that is almost equal to the usual number of pages of an entire Journal.

During the past year five meetings of each committee were listed, and reports of the proceedings of nearly every one were carefully prepared for printing in the Journal. In this respect the Journal has fulfilled its proper function in keeping all the members informed

regarding the current activities in all branches of Society work. The important function of the annual report of an officer or committee is therefore simple, and consists of two parts:

1. A summary of the items of its activities during the past year.
2. Suggestions for the lines of work which remain to be done during the coming year.

Judging by the length of the reports which have already been received, the number of pages which will be required to print them will far exceed the number required in 1938 and the preceding years. Some of the chairmen have anticipated this condition, and have most

kindly suggested that their reports be edited, if necessary.

In order that the reports may be adapted to the wishes of all the officers and committees a plan of action was suggested by President Carrington and Dr. Barkhorn, Chairman of the Publication Committee; and was printed on page 117 of the February Journal; and a reprint was sent to the chairman of each committee. The procedure which was suggested was as follows:

1. *Saturday, April 1*—A draft of the report to be completed and mailed to the Executive Offices to be set in type at once and copies of the proof be sent to each chairman.

2. *Sunday, April 16*—Each committee to meet in accordance with the schedule which was printed in each issue of the Journal beginning with the June issue; and consider the

proof of the report and make suggestions regarding its final form.

The response of the officers and committees to this plan has been gratifying. It happens that the official list of members must be printed as a supplement to the April Journal, in order that the County Societies may elect delegates whose names are on the official list. This supplement will be nearly as large as the Journal itself; and it is therefore inevitable that the April Journal will be late in mailing. However, both the office staff and the printer are willing to work over-time in order that the annual reports may reach all the officers and committees on scheduled time.

It is understood that the wishes of each officer and committee chairman will be respected, and his final directions regarding the size and form of his reports will be carried out.

The Medical History Project

The project of writing a history of The Medical Society of New Jersey has reached a stage in which a definite plan of action may be announced.

The preparation for writing the history of the State Society has consisted in reading and classifying the official records of the State Society during the first half century of its existence; and from that the outline of the story of its birth and adolescence has been unfolded. The official records of the second half century have also been read, with particular reference to the establishment of the county societies, and their participation in the activities of the State Society. The records of the twenty-one county societies are therefore as valuable and informative as those of the State Society, for the histories of all the societies are closely interwoven.

LIVES OF THE PRESIDENTS

The first step in the preparation of the medical history has been that of securing a record of the lives of all the Presidents of the State Society. A bare outline of this record was printed in the official list of officers and

members of the State Society for 1938, and is repeated this year. A chronological list of the Presidents from each county will be sent to its Secretary, to be used for the compilation of its history.

Charts of the attendance of members from each county during the early days have also been made, and will be available to the county historians.

COUNTY COMMITTEES

The discovery and utilization of the historical information requires the coördinated efforts of the State Society and its twenty-one component societies. It is therefore suggested that each county society appoint a *Committee on Medical History*, whose duties will be three-fold:

1. Ascertain the available sources of information, particularly:
 - a. The official minutes or other records of the Society.
 - b. The charter of the Society.
 - c. Biographies of prominent members.
2. Enlist the coöperation of the Woman's Auxiliary in searching for data. Many of the

doctors' wives have had experience in securing similar data for the Daughters of the American Revolution, and other historical and genealogical societies.

3. Prepare an exhibit of historical material to be shown during the annual meeting of the State Society, June 6-8, 1939, in connection with the exhibit of the Woman's Auxiliary.

MEDICAL FAMILIES

A valuable "Find" that has recently come to light is a thirty-page genealogy of the Fithian family written by Dr. Enoch Fithian, of Bridgeton, N. J., who died in 1892, aged 100 years. He was prominent in both the State Society and the Cumberland County Society. A near relative, Dr. Joseph Fithian, of Woodbury, was elected the sixty-fourth President of the State Society in 1849. A number of Fithians were active practitioners, and medical leaders, and were closely related to families, such as the Harris, Stratton, Ewing, and Bateman, who supplied six Presidents of the State Society.

It was no mere coincidence that these and other families—the Elmers and the Piersons, for example—supplied Presidents and other leaders of high rank during three or four generations. Medical and civic leadership with them were family traits. Two of the present officers of the State Society are each descended from six Presidents of the State Society. The inheritance of these traits of ability and character has been a great factor in raising The Medical Society of New Jersey to its present high rank among the Medical Societies of the several States.

RECORDING SOURCES OF INFORMATION

Equally important as securing historical "Facts" is a record of the exact *source of the information*. Many inaccuracies in historical articles relating to physicians of New Jersey have arisen from the failure of the writers to state where they obtained their knowledge. The standards of modern history demand that a brief statement of the source of each item be given, so that its details may be available to future historians.

A HISTORICAL EXHIBIT

The Committee on the Annual Meeting has made arrangements for an exhibition on *The Medical History of New Jersey*, under the auspices of the Woman's Auxiliary. The exhibit room will be near the *Scientific Exhibits*. Special efforts will be made to direct the members to the Exhibit, so that they may see it for themselves, and be inspired to assist in making the project a permanent feature of the State Society.

SURVEY OF MEDICAL SERVICES

The Survey of Medical Services under the plan of the American Medical Association is an important landmark in *modern medical history*,—which is as important as that of earlier days. The findings of the survey have been assembled in tables and charts. These are preserved in folders, which will be placed on exhibition with the historical exhibits.

The folders will show in graphic form many *facts* about which physicians have hitherto had only *individual opinions*. For example, how many doctors' prescriptions were filled by New Jersey pharmacists during the year 1938? This question will be answered in a folder made up from the records of the State Board of Pharmacy. Did you know that each year every drug store has to report the number of doctors' prescriptions which it has filled? Knowledge of the facts regarding prescriptions is essential in developing a spirit of coöperation between physicians and pharmacists.

AN ORGANIZED PROJECT

An active historical committee in each county society is absolutely essential in order to carry on the project of a medical history of The Medical Society of New Jersey. This is true because most of the original records that are yet undiscovered are to be found in the possession of families who are unaware of the importance of their heirlooms, but who will place them in the safe-keeping of the county historians. Organized effort is necessary in order to insure a continuity of the project.

ORIGINAL ARTICLES

FRACTURES OF THE LOWER END OF THE HUMERUS

By SAMUEL C. YACHNIN, M.D., Passaic, N. J.
Assistant Orthopedic Surgeon, Passaic General Hospital

An abstract of a paper presented at the October, 1938, clinical meeting at the Passaic General Hospital. These cases were taken from the orthopedic services of Dr. G. Van Schett, Jr., and Dr. F. Van Urk.

This paper is a review of all cases of fracture of the lower end of the humerus which were treated as in-patients at the Passaic General Hospital during the eight years beginning January 1, 1930. This group comprised fifty-nine cases; but only forty-two are included in this study, because we were not able to obtain an accurate follow-up of the remaining seventeen cases.

TYPES OF CASES

There were thirty-two cases of supra-condylar fractures, of which five were seen in from three months to one year after discharge; and twenty-seven from one year to eight years afterward. There were ten cases of fractures of the external condyle. Of these, four were seen from one to three months after discharge; and six cases from four months to four years afterward. Of the entire group, thirty cases were personally examined in the follow-up, while twelve were contacted by questionnaire through the mail.

There were thirty-three cases which were classified as severe fractures with displacement, usually in two planes. Of these fourteen were comminuted fractures. There were nine cases classified as minimal fractures with no displacement.

The majority of the injured were children, there being thirty-seven in this group; while five were adults. The youngest was one and a half years old, and the oldest seventy-two years.

DEVELOPMENT AND FUNCTIONS

The lower end of the humerus at birth consists wholly of cartilage and has no centers of ossification. At the age of one to two years,

the first center appears in the capitellum. This gradually enlarges and, at the age of eight to twelve years, nodules appear in each epicondyle. These enlarge and, at the age of twelve to fifteen years, the center in the capitellum unites with the one in the lateral epicondyle. At the same time, the final center in the trochlea appears. Soon after, all unite with the diaphysis except the one in the medial epicondyle, which a little later also unites and completes the development. A knowledge of this is essential to prevent confusion in the x-ray interpretation of the injured elbow. Whenever there is doubt, an x-ray of the opposite elbow should be taken for comparison. In fracture with displacement, especially at the external condyle, the x-ray may give the impression that only a small piece of bone is displaced and that it had better be left alone. However, operation may show that the entire condyle is sheared off and rotated. The confusion arises from the fact that the cartilagenous portion is not visualized. Only the small center of ossification is visible; and if this were left alone, the result would be disappointing because of interference with the growth of the epiphysis.

The lines of the fracture may run in many directions. In the usual supracondylar extension type of fracture, the line goes obliquely upwards from before backwards with the lower fragment displaced posteriorly. This is usually accompanied by either lateral or medial displacement. The flexion form of the supracondylar fracture, of which there was one in our series, is rare. This is the reverse of the one described, the lower fragment being displaced anteriorly.

There may be a fracture of either condyle, or a combination of each with the supracon-

dylar form. There may be a vertical fracture splitting the condyles alone or combined with the supracondylar form. In the fracture above the condyles, the triceps muscle plays an important part. It is this muscle which contracts and increases the posterior displacement. It must first be relaxed by traction before flexion of the elbow is made, in order to replace the lower fragment. It then acts as an efficient internal splint holding the fragments together more firmly as the flexion is increased.

The forearm makes an angle of 10 to 15 degrees laterally from a straight line with the upper arm to fashion the normal carrying angle. In females, this is slightly increased to allow for the wider pelvis. In the cubitus varus deformity, the forearm is displaced medially in relation to the upper arm and the carrying angle is lost. In cubitus valgus, the opposite takes place and the angle is increased. The normal range of motion at the elbow is about 145 degrees, flexion to about 35 and extension to about 180 degrees.

SUPRACONDYLAR FRACTURE—OUTLINE OF TREATMENT

An assistant performs counter-traction on the upper arm, while the operator applies direct traction to the forearm. This is accomplished slowly and steadily without a jerking motion, until overriding is overcome. Then, with the thumbs of both hands anteriorly on the lower end of the shaft and the fingers behind the lower fragment, this is levered forward into position. The forearm is flexed only after this maneuver is completed. It is then held in mid-pronation and fixed either by adhesive around the arm and forearm and a cuff and sling around the neck, or a figure-of-eight bandage, or a posterior splint of plaster of paris extending from high up on the arm to below the wrist.

Reduction should be made immediately, if possible, and the patient should be kept under observation for at least seventy-two hours, so as to note any evidence of complication.

SKELETAL TRACTION

If the patient comes late, or repeated manipulation is unsuccessful, or if the fracture is a complicated one, *skeletal traction* can be em-

ployed. The patient is placed in bed in the supine position, and a Conwell frame, made of wood, is attached to the side of the bed parallel with the shoulder. Under local anesthesia, a Kirschner wire is inserted into the olecranon process of the ulna slightly towards its shaft, in order to pull the condyles forward of the line of the shaft. The elbow is then flexed at a right angle and skin traction straps are applied to the forearm, perpendicular to the ceiling and two or three pounds of weight are attached over pulleys to these. The fingers are left free. A yoke is fixed to the Kirschner wire and seven to ten pounds are attached with the traction in the line of the humerus. The line of pull can be changed as necessary. This apparatus can be left in situ until union is obtained, or a posterior cast may be applied in several days and the patient made ambulatory. This treatment is almost invariably successful and is much more to be desired than operative interference, with its resultant trauma and possible overgrowth of callus. It is especially applicable in adults.

Too early motion is undesirable. In the less severe fractures, the forearm is lowered to a right angle at three to four weeks and a little motion in flexion is allowed. After four weeks the active range of motion becomes increased, and baking and massage are then used. In the more severe cases, motion may be delayed a little longer, but physiotherapy is instituted even earlier. We do not attempt to lay down any hard or fast rules. Function, especially in children, will often quickly return when the arm is removed from its immobilization, and the child is left free to use it.

EXTERNAL CONDYLE FRACTURE

In the treatment of the external condyle fracture, which is the next most common type, each patient presents an individual problem. It is treated in the same way with manipulation and immobilization in flexion. During traction, it is better to completely supinate the forearm and relax the supinator longus, which is attached to the external condyle.

Because this fracture is often accompanied by a rotation of the broken fragment, and because the small size of the fragment makes it

difficult to control by closed manipulation, open operation has an important place in the treatment. The operation is usually simple and attended by little trauma. The fractured fragment can be held in place with a periosteal suture, and locked there when the elbow is flexed. Some surgeons use a bone screw, but we have not had to resort to this procedure.

COMPLICATIONS AND TREATMENT

We did not encounter any nerve injuries. We did not have any cases of Volkman's ischemic contracture. There were ten cases, however, with marked edema and embarrassment of the circulation, ranging from the mild form with mild cyanosis, to complete obliteration of the pulse, anesthesia, and loss of motion of the fingers. We feel that we were able to avoid a most tragic result by our constant observation of each case that presented any swelling of any degree, and by the use of proper treatment according to principles well defined. Vertical traction either by skin straps alone in the very young, or Thomas splint and skin traction in the older patients, until the edema subsides, should be used before final manipulation is attempted and flexion is performed.

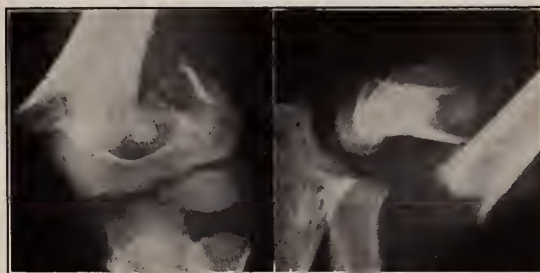
During this time, local heat either by infrared lamp or hot wet packs should be applied. Stroking massage aids the subsidence of the edema. Hematomas should be aspirated. If the swelling shows no signs of subsiding and the circulatory embarrassment continues, one should be prepared to do a fasciotomy in the anterior cubital space. A matter of three to four hours will make the difference between recovery or failure. This is an emergency condition and neglect means tragedy. Unless the large anterior cubital vessels are torn grossly and bleeding goes unchecked, these measures will forestall this complication. We treated seven cases with traction in a Thomas splint before final reduction,—one case for eight hours, and the others from two to five days.

Three quite young children were treated by skin traction and vertical suspension with the straps tied to a frame at the side of the bed. In one case, a large hematoma was aspirated.

PRESENTATION OF CASES

CASE 1

F. DeB., a male, aged seven, fell off a swing on August 27, 1937. There was a supracondylar fracture with comminution. The antero-posterior view shows the condyles displaced laterally, and angulated obliquely. The lateral view shows the condyles displaced posteriorly and angulated, with overriding of one-half inch.



Antero-posterior Side View

Fig. 1, Case 1—Fractured Elbow

The arm was immediately manipulated under ethylene anesthesia, and a posterior plaster splint applied in the usual manner with the elbow in acute flexion. The antero-posterior and lateral views show complete reduction.

This case was seen one year later, with a very satisfactory cosmetic and functional result.

CASE 2

P. A., a male aged twelve, who fell from a tree at a height of twenty feet, was admitted on September 9, 1936. On admission there was reduced circulation, the skin temperature was lowered, sensation was absent from all of the fingers except the fifth, and adduction of the fingers was impaired.



Antero-posterior Side View

Fig. 2, Case 2—Fractured Elbow

(Fig. 3.) The antero-posterior view shows the condyles comminuted and displaced one inch laterally. The lateral view shows a complete displacement of the condyles backwards with one inch overriding. The shaft is almost protruding through the skin anteriorly. The fracture is a supracondylar extension type.

The elbow was immediately manipulated under gas-ether anesthesia, and placed at right angles in mid-pronation; and a plaster cast applied in the usual manner. The patient was placed in bed, the arm elevated on a pillow, and light radiant heat with massage to the forearm was applied. Motion and sensation returned to the hand in several hours and the edema gradually subsided. The x-ray showed the lateral displacement corrected in the antero-posterior view. The lateral view presented only partial anatomical reduction with about one-half of the width of the shaft protruding forward as a sharp edge.

The x-ray one month later showed no change. The x-ray eighteen months later showed a complete rounding off of the sharp edge and complete reconstruction of the internal bony cortical lines.

At the beginning of convalescence, flexion was limited to 100 degrees. The final review showed a satisfactory cosmetic result and only a ten-degree loss of flexion. The patient was very coöperative and the constant improvement dissuaded us from operative interference.

CASE 3

D. A., a female aged nine, who fell from a ten-foot height, was admitted on August 4, 1937. The x-ray showed a supracondylar fracture with slight medial displacement in the antero-posterior view, and complete posterior displacement with overriding in the lateral view. There was marked swelling at the elbow which did not allow complete flexion after manipulative treatment. This was done immediately under gas-oxygen anesthesia, and a cast was applied. The x-ray showed a partial reduction, with some posterior displacement remaining in the lateral view.

The edema increased and required removal of the cast. Vertical suspension was applied by skin traction straps for two days. Another manipulation was then attempted and the elbow flexion was increased. The lateral x-ray showed, however, that the posterior displacement had increased, and that there was still some overriding present. Accordingly, six days after the injury, skeletal traction was applied. The x-rays show the Kirschner wire in place and the overriding and most of the deformity overcome.

Three weeks after the injury the wire was removed, a posterior cast was applied, and the patient was made ambulatory. She was treated with baking and massage for several weeks. One year later the review showed a satisfactory cosmetic result and only five degrees loss of flexion.

CASE 4

E. M., a male aged six, was admitted on October 3, 1934. The x-ray in the antero-posterior view showed a comminuted fracture of the external condyle with rotation, so that the capitellum pointed to the olecranon process. The lateral view showed the fragment displaced distally, and angulated.

Under ethylene anesthesia, an immediate attempt

was made at closed reduction, and the forearm was fixed in flexion with a posterior cast. This was unsuccessful and three days later an open operation was performed. A lateral incision was made, a small loose piece was removed, and the fractured condyle was sutured to the shaft with a double plain catgut suture. The postoperative x-ray showed the capitellum in its corrected position.

This case was reviewed four years after the injury and presented a very satisfactory cosmetic and functional result.

CASE 5

F. P., a male aged thirty-five, was admitted on August 10, 1934. The antero-posterior view showed a comminuted fracture of the external condyle, with the fragments displaced laterally and a loose piece internal to the head of the radius. The oblique view showed the loose fragment displaced forward.

The elbow was markedly swollen, thus causing embarrassment of the circulation. This subsided after the arm was placed in a Thomas splint with seven pounds traction for two days. Then, under ethylene anesthesia, reduction was attempted and the arm was placed in flexion with a posterior cast. The x-ray demonstrated the condyle in fair position, but a large loose piece remaining anteriorly.

An x-ray taken three and one-half years later showed marked excuberant callus, and periarticular thickening. This case was finally reviewed four years after the injury, and presented the following result: Extension was limited to 120 degrees, and flexion to 70 degrees, making a total motion of 50 degrees. The carrying angle was normal. The function has remained the same since one month after the injury.

SUMMARY OF RESULTS

The cases were classified as very satisfactory when no deformity, no disturbance of function and no evidence of injury resulted. The satisfactory group included those cases with no deformity but a mild loss of function. The unsatisfactory group included those that had either marked loss of function or deformity, even though the function was good.

There were nine cases of fracture without displacement. All of these had a very satisfactory result. Of the thirty-three cases classified as severe, twenty-one presented a very satisfactory result.

Five cases had a satisfactory result as follows:

- 1 case — 5-degree limitation of extension
- 2 cases — 5-degree limitation of flexion
- 1 case — 10-degree limitation of flexion
- 1 case — 20-degree limitation of flexion

There were seven cases that presented an unsatisfactory result, as follows:

- 1 case—80-degree total motion
- 1 case—70-degree total motion
- 1 case—50-degree total motion
- 1 case—Marked cubitus varus
- 1 case—10-degree cubitus varus and 5-degree loss of flexion
- 1 case—5-degree cubitus varus and 10-degree loss of flexion
- 1 case—80-degree total motion and 10-degree cubitus varus with the condyles deformed and the external condyle displaced posteriorly

We then tabulated the cases in order to compare the anatomical reduction with the final cosmetic and functional result, as follows:

SUPRACONDYLAR FRACTURES

- 15 cases—completely reduced—all very satisfactory results
- 11 cases—residual posterior displacement—one poor functional result
- 3 cases—residual medial displacement—all satisfactory functional, but poor cosmetic, results
- 1 case—a loose piece not removed—satisfactory result
- 1 case—operated upon—very satisfactory result
- 1 case—residual lateral displacement—result, cubitus valgus but good function

EXTERNAL CONDYLE FRACTURES

- 7 cases—completely reduced—very satisfactory results
- 1 case—not reduced—poor result
- 2 cases—operation and reduction—very satisfactory results

CONCLUSIONS

Good anatomical reduction gives very satisfactory results. Residual posterior displacement, even to one-half of the width of the bone, will be compensated for in time, in children, and a satisfactory result can be expected unless there is marked periarticular injury.

In adults, however, this is not true. Residual medial displacement leaves a residual cubitus varus, but this is not incompatible with satisfactory function. Residual lateral displacement leaves a cubitus valgus, yet satisfactory function may result. A loose piece allowed to remain anteriorly will cause a bone-block in flexion. Close observation and careful, prompt treatment will materially reduce the incidence of Volkman's ischemic contracture. Severe tissue injury and periarticular thickening may give a poor result despite good anatomical reduction.

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CLINICAL ASPECTS OF TUBERCULOSIS IN SCHOOL CHILDREN

By IRVING L. APPLEBAUM, M.D., Newark, N. J.

Read before New Jersey School Physicians Association, May 20, 1938, at Atlantic City, N. J.

Childhood tuberculosis is really a misnomer, for the so-called childhood type may occur in adults, and the adult type in children. A better name would be the primary type of tuberculosis, which may present post-primary sequelae; and then later undergoes a gradual transition to the adult type.

THE PRIMARY TYPE

For a better understanding of the problem, it is essential to review the pathogenesis.¹ The

response of the pulmonary tissue to a primary infection with the tubercle bacillus is a circumscribed lesion, which may be situated in any part of the lung. The primary lesion in the parenchyma of the lung consists of one, or in rare cases, more than one tuberculous focus, is situated just beneath the pleura, and rapidly undergoes caseation in its center. Closely following this lesion there is an extension into the regional lymph nodes at the hilum of the lung by way of the lymphatics; so that there

always occurs as an expression of the first infection a primary focus underneath the pleura and a corresponding lesion in the lymph nodes at the hilum. This entity is often spoken of as the "Primary complex". In favorable cases, by far the majority, the caseated area remains small and becomes encapsulated by a wall of fibrous tissue and infiltrated with calcium. The same train of events takes place in the regional nodes.

In unfavorable cases the primary lesion does not come to a standstill, and a spread takes place in one of the following ways:

1. Parenchymatous spread.
2. Invasion of lymphatics between the primary lesion and regional lymph nodes.
3. Increase in the lesion of the lymph nodes. This may even break into the bronchus and cause an aspiration tuberculous lesion in the basal portions.
4. Invasion via lymph nodes to lymphatics and blood stream, with a deposit of bacilli into the lung, brain, bones, kidneys, and other systems—the so-called "Organo" stage.

THE SECONDARY TYPE OF INFECTION

Usually at a later stage in life (from adolescence on) the adult type of tuberculosis makes its appearance. This form of reinfection may be exogenous (outside contact), or endogenous (from previous lesion). Although there are strong protagonists with attractive theories for each, both possibilities must be recognized.

The mortality and morbidity of tuberculosis is very severe in infancy. Then there seems to be a latent period until adolescence. J. A. Meyers² states that due to the low morbidity and mortality, the period from two or three to ten or eleven is considered one of inactivity of the disease. However, this is really a smoldering stage, and bears close watching. Thus, as a rule, in children in the grades, we do not deal with severe forms. In the high school group either the adult type, or latent apical lesion may occur. This is a rather treacherous and insidious form, because it gains a foothold without warning. Hetherington and others³ reported latent apical lesions in one per cent of a large group of high school children

who were x-rayed. However, deviations from this average cross-section may present themselves. Any type may be found in any of the age groups in children, and it behooves school physicians to look for and understand each form. In harmony with our own experience, Hetherington and others³ found x-rays positive for tuberculosis twice as common in adolescent girls as boys, and four times relatively as frequent in the colored as the white. From a viewpoint of incidence, we can also appreciate the relatively high frequency in schools in which districts are crowded and of the lower social strata.

As the child is viewed clinically, we may note that the contact history is sometimes revealing, and that the diligence of the interrogator is an essential factor in producing suggestive leads.⁴ In the younger group, intra-familial contact can be more often established; and in the older cases, extrafamilial sources are frequently exposed. However, the origin may sometimes be an apparently innocent carrier. Unfortunately this link is sometimes difficult to uncover.

SYMPTOMS

Symptoms often fall in a disappointing category. A complete absence of subjective symptoms is not uncommon. Fatiguability out of the ordinary for the particular individual, and a slight daily rise in temperature, rank foremost. Cough, expectoration, chest pain, hemoptysis, and loss of weight are rarely found, and are usually the complaints of the more advanced cases, when the lung is more extensively involved.

A paucity of physical signs is another outstanding observation. Even after checking with x-rays it has been our experience at the Babies' Hospital, Newark, New Jersey, to be unable to localize pathology by physical means. The stethoscope is far from being potent. As for D'Espine's sign, employed particularly by the French school where it originated, no value can be placed on it, and in our opinion it can be definitely discarded.

Thus we are compelled to resort for diagnostic purposes in school children to the *tuberculin test*, and *x-ray studies* of the positive re-

actors. In the final analysis, our evidence rests chiefly with these two procedures—they comprise our real machinery. Boyd⁵ reports an incidence of approximately 20 per cent positive reactors in a large series of children entering school. The incidence of tuberculosis demonstrable by x-ray in his series was seven times as great for those with a three-plus reaction, as for those with a one-plus reaction.

The relationship of sensitivity to degree of the lesion is still controversial. It is interesting to note that reports in the literature vary from 6.3 per cent⁶ to 48.1 per cent⁷ positive reactors in similar age groups.

One must also be able to recognize extrapulmonary complications. Tuberculosis of the bones, kidneys, ears, larynx, and gastro-intestinal system are not rarities. When death takes place in children, it is most often caused by tuberculous meningitis or generalized tuberculosis. Such hazards were much greater for children with parenchymal lesions, and this fact has been reported by Brailey⁸ in a prolonged study.

That a child may have a positive tuberculin and suggestive x-ray signs, without a tuberculous lesion, has been recognized by Nissler⁹ and others. We frequently find this seeming paradox in our study at the Babies' Hospital; and from a viewpoint of differential diagnosis consider such pathological states as bronchiectasis, lung abscess, sinus-bronchial disease, unresolved pneumonias, cysts, etc.

TREATMENT

Treatment may be simply divided into the following classifications:

1. *Observation Cases*—Positive tuberculin and no x-ray findings. There is no treatment,

and patients are checked every six months.

2. *Preventorium Cases*—Positive tuberculin with mild primary lesion or latent apical adult type. A modified regime is planned. The child may continue with school, but no gymnasium exercises are allowed, and greater rest periods enforced. This child is reexamined every one or two months.

3. *Sanitarium Cases*—Severe primary lesions or definite parenchymal lesions (adult type). These cases should receive the equivalent of sanitarium care, or enter a sanitarium. It is not within the scope of this paper to discuss collapse therapy, but it can be utilized in school children. At Essex County Isolation Hospital all forms have been employed with efficacy, including phrenic nerve surgery, artificial pneumothorax, thoracoplasty, oleothorax, etc.

DISCOVERY OF THE ORIGINAL CASE

One point must be stressed, regardless of the type of treatment. That is the breaking of the contact with the patient who causes the infections. Any mode of therapy is of no avail, if the source is continuously exposing the child to more dosage.

Once a case of tuberculosis in children is uncovered, the search for the source should begin. Breaking of the contact is really an essential part of the treatment. Every member of the household, and suspicious extra-familial contacts, should have roentgenograms taken. Of course fluoroscopy is more economical, but not as accurate. However, finances usually interfere with such an ideal program. If the source is found, the child is benefited, a new case is uncovered and treated, and the community benefits, for one more hazard is removed.

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LYMPHOGRANULOMA VENEREUM

REPORT OF A CASE; WITH OBSERVATIONS ON THE MICROPATHOLOGY OF THE FREI TEST

By IRVING M. ARIEL, B.A., M.D.

From the Paterson General Hospital, Paterson, N. J. Read at the "Internes' Night" before the Passaic County Medical Society, September 10, 1936.

Lymphogranuloma venereum is a venereal disease caused by a filterable virus. Its occurrence is so common that it is beyond the stage where single cases are to be reported. It is, however, so frequently overlooked that the case presented below may serve to illustrate some of the salient features of this malady.

The various clinical manifestations that this disease may assume have resulted in numerous classifications and various definitions of the lesions produced by this disorder. It was first described by Hunter in 1786 as suppurating inguinal bubo (climatic bubo). Climatic bubo has been recognized in the tropics for many years, but it was not until 1913 that Durand and Favre described a disorder of the temperate climate which they called lymphogranuloma inguinale, and which has since proved to be identical with climatic bubo.

In 1925 when the Frei test was first introduced, the precise nature of the numerous clinical entities became better understood, and were correlated as infections from the same virus which causes climatic bubo. Among these may be included esthiomeme, chronic elephantiasis, and ulceration of the vulva, lupus vulvae, syphiloma of rectum, chronic non-specific hyperplastic infiltration of rectum, rectal strictures, vulval condylomata, recto-vaginal fistula, and others. The various disorders described have been considered either as separate clinical entities, or of luetic or tuberculous origin. Due to the exact results of the Frei test, it is now possible to include the above conditions under the single term of *lymphogranuloma venereum*.

The Frei test consists of the intradermal injection of specially prepared material aspirated from an inguinal bubo. A positive reaction consists of a dome-shaped weal at least one-half centimeter in diameter which appears from 48-72 hours after injection. There is generally an erythematous border, and at times a small central necrotic area. The histopathology of the test is discussed below.

Thus lymphogranuloma venereum is a sixth venereal disease being added to the five other venereal disorders, namely: syphilis, gonorrhea, chancroid caused by the *Bacillus of Dugrey*, the genital lesions caused by Vincent's organism, and granuloma inguinale.

The onset generally occurs about five to seven days after intercourse as a small papular vesicular lesion on the penis in males, and around the fourchette in females. It ulcerates and quickly disappears. A loose, white urethral discharge may occur. Inflammation of the regional lymph nodes and surrounding tissues soon follows. In most instances numerous small foci of necrosis with suppuration occur in the lymph glands. Constitutional symptoms may occur;—these include fever, malaise, anorexia, rash, arthralgias, loss of weight, headache, and general body pains.

In the males the lymphatic drainage of the penis is to the inguinal and crural glands, the involvement usually going to these glands first and producing a suppurating inguinal bubo (climatic bubo). In the females the anterior portion of the vulva drains to the inguinal and crural glands. The posterior portion drains freely into the glands of the rectal region, being brought into connection with the ano-rectal, lateral sacral, and posterior rectal wall lymphatics. Involvement in the female may go to the inguinal and crural glands and produce an inguinal bubo as in males; or more commonly extend into the intrapelvic glands directly, and subsequent inflammatory and cicatricial reaction, especially a secondary non-specific proctitis and periproctitis, causing rectal strictures and the genito-ano-rectal syndrome.

At times the primary lesion persists, thus setting up a marked reaction, and a chronic lesion ensues. A blockage of the genital lymphatics may produce an elephantiasis or lymphedema of the genitals.

There are thus three distinct types which are not infrequently combined, namely:

1. Inguinal bubo.
2. Rectal strictures (genito-rectal-ano syndrome).
3. Genital lesions which include elephantiasis and lymphedema.

The following report deals with a case of lymphogranuloma venereum, inguinal bubo type.

CASE REPORT

The patient is a forty-five-year-old Greek cook who was admitted to the surgical service of Dr. Deyoe at the Paterson General Hospital wearing a truss. His ailment was diagnosed as inguinal hernia, with gonorrheal and syphilitic adenitis. He complained of an inguinal mass of three weeks' duration. The patient had had gonorrhea seventeen years previously, and five or six times since.

He believes the present condition arose from intercourse with a white woman seven years ago. One week following coitus, he developed a small, punched-out ulcer on the penis at the corona. The ulcer exuded a dirty fluid and healed slowly. Two days after the appearance of the ulcer, he noted a swelling in the left groin. This swelling became red and tender, but did not suppurate. He received intramuscular injection therapy. The swelling persisted for several weeks and then disappeared. At the same time he developed headache, anorexia, malaise, and loss of twenty-five pounds of weight. He has had no recurrences until three weeks before admission (seven years following the subsidence of the previous adenopathy), when a swelling again appeared in the left groin which has become red, tender, and progressively larger. He has no other symptoms.

Physical examination reveals a well-nourished, white male. He presents a large left inguinal mass the size of a large lemon. The overlying skin appears thickened and of a copper-red hue. No other signs were present.

Laboratory data negative. Repeated Wassermann tests were negative.

A diagnosis of lymphogranuloma venereum was made, and was later confirmed by a strongly positive Frei test, and the histological picture of the glands. The mass was removed by Dr. Rubé. The wound healed well except at one point where a drain was left in, and a chronic draining sinus persisted which slowly healed. Local applications of glycerine gave marked relief.

PATHOLOGICAL EXAMINATION

The excised mass consisted of broken-down glands matted together by edematous granulation tissue. The capsule was greyish, granular, and thickened. There were many minutely raised yellowish opaque abscesses, diffusely scattered over the entire gland. The gland was soft, flabby, and greyish-red in color.

Histologically the general architecture of the gland was retained. There was generalized hyperplasia of the gland reticulum. The lymph follicles were enlarged. There was proliferation of the sinus endothelium, and marked infiltration of pleomorphic cells, consisting of polymorphonuclear neutrophils, eosinophils, plasma cells, large mononuclears and a few multinucleated giant cells of the Langhans type.

The yellow opaque abscesses seen grossly consisted of large mononuclears, and many layers of epithelioid cells, among which were a few giant cells, arranged radially around a central necrotic core. The necrotic core consisted of degenerated necrotic finely granulated material, mononuclears, and broken-down polymorphonuclears. (Fig. 2.) Chromatin staining material was seen in the large mononuclears and also lying free. These are called Gamna bodies after Gamna, who first described them. He believed they represented cell inclusions associated with the virus. It seems more plausible that they represent nuclear debris.

Many such abscesses were found scattered throughout the section. (Fig. 1.) This is a characteristic of early cases. In later cases the specific lesion may be masked by a marked fibrosis and plasma cell infiltration.

The above description of the gross and microscopic gland is very characteristic of the disease, and diagnostic biopsies of lymph nodes should be taken to confirm a diagnosis when in doubt.

PATHOLOGY OF THE FREI TEST

A section of skin showing a positive Frei reaction was removed for biopsy sixty hours after the injection of the antigen. Grossly, it consisted of a hard, indurated area about one and a half centimeters in diameter, with a central greyish necrotic core and an erythematous border. Microscopically the epidermis was thickened. At one point there was a dissolution of epidermis, leaving a cavity of fine amorphous material, which consisted of broken-down cells for the greater part. The contents of the necrotic area were not unlike the necrotic core noted in the abscesses of the lymph nodes. The core was surrounded by connective tissue in which were many lymph cells. The surrounding erythematous border represented a secondary non-specific congestion and tissue reaction about the necrotic nodule.

This picture agrees in many respects with the description of the micropathology of the Frei test recently described by Kornblith, except for the formation of a definite epithelioid nodule around the necrotic core. The histopathology is similar to the micro abscess found in the lymph nodes. Kornblith claims it is similar to the microscopic picture of the primary lesion, and that it may be considered as the histopathological unit of the disease.

Thus the pathogenesis of the numerous and

varied lesions that the disease may assume is explained as follows: The primary lesion on the genitals demonstrates the fundamental pathological unit in its simplest form, consisting of a microabscess which contains a central granular necrotic core surrounded by many layers of epithelioid cells, mononuclears, and a few giant cells. In the central core are seen necrotic debris, broken-down polynuclears, mononuclears, and the so-called Gamna bodies.

The reaction produced by a positive Frei test duplicates this lesion in every detail.

The disease process spreads by way of the lymphatics to the neighboring lymph glands where numerous histopathological units are set up in the form of discrete microabscesses described above. If the necrotic core of the abscess invades the epithelioid border and extends to the skin, sinuses form. Each sinus drains an abscess and exudes a yellowish, purulent material. The sinuses are not infrequently multiple and the irritation of the draining material often produces ulcerative lesions of the skin.

The individual infective foci may coalesce, and set up larger abscesses within the gland. A secondary perilymphadenitis causes the lymph nodes to become matted together. With extensive destruction of the inguinal glands, elephantiasis of the penis, scrotum, and vulva may ensue.

When the intrapelvic glands become involved they enlarge and become necrotic, often setting up a non-specific reaction. With involvement of the rectal glands there is a secondary rectal reaction, resulting in fistula-in-ano, proctitis, proctitis and condylomata. The enlarged perirectal and perianal lymph nodes and the proctitis and periproctitis with a resulting fibrotic reaction produce rectal strictures.

Extension of the necrotic material from the rectum to the vagina or bladder may produce a recto-vaginal or recto-vesical fistulae.

General adenopathy may occur. There are several cases on record of surgeons who infected their fingers while treating patients with lymphogranuloma venereum and developed axillary adenitis in all ways typical of the disease. There is no evidence to show that the blood stream is infected.

INCIDENCE

It is difficult to determine the actual incidence of this disorder, because the diagnosis is so frequently missed. Frei claims that in Berlin 300 to 400 new cases are reported annually. Clément has estimated that ten per cent of the prostitutes in France have positive Frei reactions. In this country the disease is much more prevalent than is commonly believed. It is very common in Southern United States, and is also quite prevalent in this part of the country. At the Mount Sinai Hospital in New York over 100 cases have been reported in a period of three years. The disease has recently been made reportable to the New York Board of Health, and it receives an average of four new cases per week. (Personal communication with Kornblith.)

It is more common in Negroes. This disorder has been described in practically every country in the world.

TREATMENT

The treatment is still in an experimental state. Spontaneous resolution and cures do occur. Numerous therapeutic agents have been employed, and the very number suggests that no real satisfactory type has been developed. Among the measures employed are quinine, emetine, tartar emetic, stibonal, organic arsenicals, iodine, methylene blue, solygonal, x-ray, ultra-violet light, and radium.

Reports by Kornblith from the Mt. Sinai Hospital, New York, of intravenous injection of Frei material have been quite promising. The collected pus from patients' glands is heated to 60 degrees for two hours on one day, and on the following day heated to 60 degrees for one hour, and kept in sterile containers. The patients are kept ambulatory and receive one-half a c.c. intravenously three times a week.

In glandular cases the results are very promising. Clinical cures are effected in from one to two months. Aspiration of the glands in some cases supplement the vaccine therapy. Massive excision of the glands has been discontinued because of the possibility of setting up an elephantiasis of the genitals following excision.

In the genital lesions the results were fair. Longer periods of treatment were necessary and complete clinical cures did not result.

In the rectal lesions the vaccine therapy gave some palliation, but did not affect the existing pathology. The results appeared promising

when the vaccine therapy was first instituted, but after one to three months the vaccine had little or no effect. Colostomy and rectal resections were necessary in several instances.

Thus vaccine therapy has a definite place in the treatment of this malady.

PARTIAL AND COMPLETE OBSTRUCTION OF THE URETERS AS A ROENTGENOLOGICAL PROBLEM

By B. H. NICHOLS, M.D., Cleveland Clinic, Cleveland, Ohio

First William G. Herrman Lecture. Read before the Section on Radiology of The Medical Society of New Jersey, on May 18, 1938.

Obstruction of the ureters should be a subject of the greatest interest to general practitioners as well as to specialists. This is particularly true because many cases of ureteral obstruction are accompanied by symptoms which are confined mostly to the abdomen and which simulate very closely diseases of other organs. A review of a large group of cases of ureteral obstruction shows that in a large percentage, particularly that group in which there is no definite abnormal change in the urine or in those cases not accompanied by symptoms of disturbances in the bladder, the diagnosis is made very late and, in many instances, only after the patients have been submitted to one or two operations which have not afforded relief.

It is hoped that this discussion of ureteral obstruction will stimulate a greater interest in this subject with the result that correct diagnoses may be made more often and at an earlier period in the existence of the disease. This is especially important because it is well known that long-continued ureteral obstruction usually produces marked damage to the kidney on the affected side and may be accompanied by almost complete destruction of the kidney or result in the formation of stones in the kidney or secondary infection due to retention of urine.

In order to appreciate more fully the cause of these changes, it is pertinent to review briefly the anatomy, physiology, and innerva-

tion of the ureter. The ureter is a flattened tube which extends from the outlet of the kidney pelvis to the angle of the vesical trigone, where it empties into the bladder. It may enter the bladder at almost a right angle to the wall, or it may enter in a rather marked oblique course.

The ureter is composed of three coats—a fibrous outer coat, a muscular middle coat, and an inner epithelial coat or mucosal lining—underneath which lies a layer of submucosal tissue composed of elastic fibers and connective tissue. The middle or muscular coat is composed of unstriated fibers.

BLOOD SUPPLY

The vascular supply of the ureter is abundant, being derived from several sources, and it is freely anastomosing. The renal artery supplies the upper third of the ureter; branches from the aorta and common iliac, the inferior mesenteric, or spermatic supply the middle third; while the lower third is supplied from the vesical arteries and the vas.

NERVES

The nerve supply of the ureter is also of very great importance in the study of ureteral obstruction and particularly in the study of referred pain (Fig. 1). The nerve supply is an intricate meshwork of small fibers. The outer fibrous sheath of the ureter carries the nerve supply, the innervation coming mainly from

the renal, spermatic, ovarian, and hypogastric plexuses. The vesical plexus also supplies a portion of the lower end of the ureter. The afferent fibers come from the tenth, eleventh, thoracic, and first lumbar vertebrae. The efferent fibers are also in the vagus supply to the ureter. A few ganglia are found in the lower

RESULTS OF OBSTRUCTION

The results of partial or complete obstruction of the ureter must be understood if correct diagnosis and treatment are to be instituted. It has been shown that, if the ureter is completely obstructed *permanently*, atrophy and nonfunction of the kidney take place; while

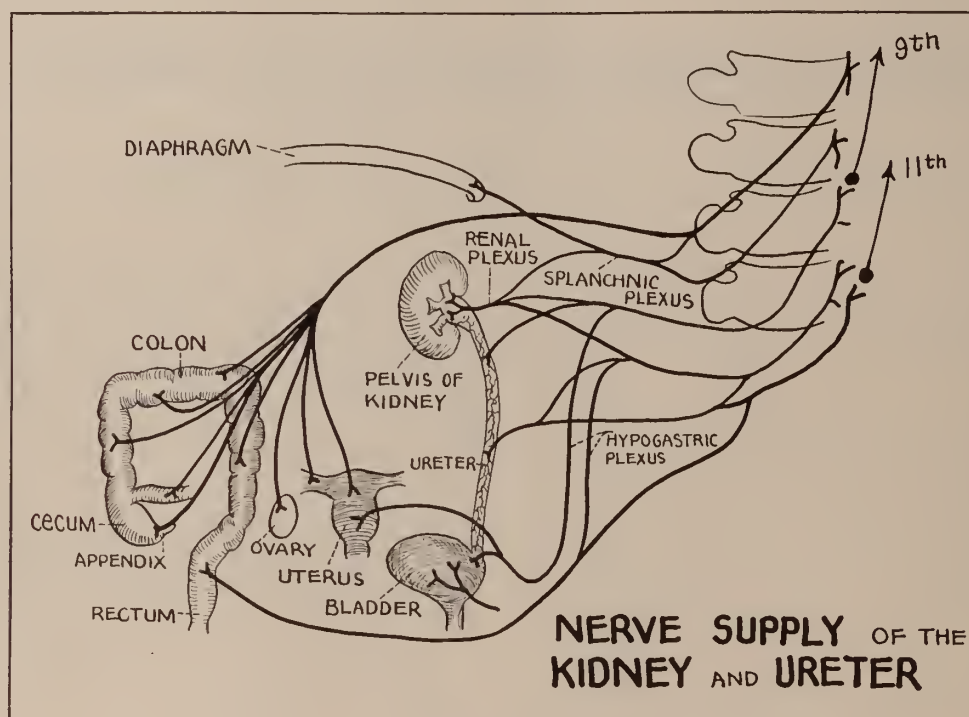


FIGURE 1

Nerve supply of the kidney and ureter.

third of the ureteral segment. The definite anatomical structure of the innervation of the ureter, however, has not been accurately demonstrated. It is interesting, experimentally, that all the nerves supplying the ureter may be cut, and yet its contractions appear to continue normally. Even a cut section, completely taken from the ureter, is seen to contract rhythmically after removal, and little influence can be induced in the ureter by stimulation from the hypogastric nerves or by the administration of adrenalin. There is no sphincter at the lower end of the ureter; apparently it is closed by the contraction of the bladder wall and, it is believed, by a reflex contraction of the lower portion of the ureter.

intermittent or partial obstruction results in a marked dilatation of the kidney, causing hydronephrosis with accompanying pain and urinary stasis which result in infection or the formation of renal calculi.

From a clinical standpoint, *pain* is usually the first symptom of any degree of obstruction that overdistends the kidney pelvis. Because such pain may be referred to the gastro-intestinal tract and simulate a spastic colon, or to the region of the gall-bladder simulating gall-bladder colic; and because it may simulate lesions of the spine, angina pectoris, and many other symptoms, the pain of hydronephrosis may continue for a long time before its true etiology is determined. It may be stated quite

truthfully that hydronephrosis presents no characteristic symptoms, and usually is recognized only by inference; therefore, one should always bear in mind the possibility that such a condition may be present. Since early hydronephrosis causes no abnormal change in the urine, attention is often not directed to the possibility of ureteral obstruction.

ABDOMINAL EXAMINATION

For a number of years it has been our policy to make a careful examination of the abdomen in order to determine the size and shape of both kidneys, as well as the presence or absence of visible calculi, before any examination is made with opaque media for a study of the gall-bladder or gastro-intestinal tract. It has been possible by this procedure to determine in a large number of cases the presence of a stone, either in the kidney or ureter, which had heretofore been unrecognized; to discover the presence of a tumor of the kidney as shown by the abnormal change in the contour of this organ; and also to determine the presence of a large kidney on one side suggesting the presence of hydronephrosis. We consider this procedure to be very important, and we advise that all patients who are suffering from abdominal pain have such an examination made as the first roentgenological diagnostic procedure.

CAUSES OF URETERAL OBSTRUCTION

Calculus.—First among the causes of obstruction in the upper portion of the ureter is a ureteral *calculus* which may be free in the pelvis of the kidney and at times enter the upper end of the ureter (Fig. 2), producing temporary obstruction, distention of the kidney pelvis, and acute renal colic. Such a stone may be one that is not visualized by plain films. If such a stone is suspected, a pyelogram made with media of ordinary density will show it as a nonopaque shadow (Fig. 3). This is true also when a stone has left the kidney and lodged in the upper end of the ureter. In such a case the passage of the catheter may meet with obstruction and thus the location of such a stone is determined.

Tumor.—If the plain film shows the presence of a nodular enlargement of either pole of the kidney, a *tumor* should be suspected. It

is usually believed that kidney tumors produce hematuria; and if there is no blood in the urine the presence of a tumor is questioned. However, in a large series of kidney tumors, excluding the squamous cell and papillary types, more than 50 per cent of 100 patients had had no evidence of blood in the urine. Therefore, the diagnosis of such a lesion necessitates the



FIGURE 2

Kidney stone producing intermittent obstruction of the upper end of the ureter.

making of a pyelogram or an intravenous urogram to establish the correct diagnosis. Kidney tumors, either malignant or benign, at the lower pole of the kidney may be of such size that they cause mechanical obstruction of the ureter and produce pain and retention in the affected side (Fig. 4). In tumors causing hemorrhage, blood clots may lodge in the upper part of the ureter and produce obstruction.



FIGURE 3
Non-opaque stone in the left kidney.

These, however, will usually be recognized by the presence of blood in the urine.

Infection.—Obstruction of the upper part of the ureter may be due to infections in the kidney. These usually are suspected because of the presence of pus in the urine and often because of accompanying cystitis, particularly in the presence of a tuberculous infection. Tuberculous infection of the kidney and the ureter will be discussed later.

Anomalies of the kidney and anomalies of the blood supply to the kidney constitute perhaps the most difficult obstructions from the standpoint of diagnosis. The kidney is supplied by the renal artery directly from the abdominal aorta which, in the average normal individual, usually enters the pelvis of the kidney. There may, however, be aberrant vessels to either pole



FIGURE 4
Hypernephroma of the kidney producing obstruction of the upper end of the ureter.

of the kidney, these either coming directly from the abdominal aorta to the poles of the kidney or being branches from the renal artery. These vessels are definitely fixed to the aorta and in the lower pole they pass directly under the ureter. If ptosis occurs in such a kidney, the ureter becomes redundant, the aberrant vessel becomes taut by its fixed attachment to the aorta, and intermittently obstructs the ureter at the ureteropelvic junction (Figs. 5a and 5b). In such a case there will be no clinical symptoms except intermittent attacks of pain; and these are always accompanied by normal urine. These attacks simulate those diseases of the upper abdomen which are accompanied by pain. If such attacks have continued for a considerable time, roentgen examination may



FIGURE 5a

Anomalous vessel of the left kidney producing obstruction of the upper end of the ureter.



FIGURE 5b

Anomalous vessel producing obstruction of the upper end of the right ureter.

reveal a rather marked hydronephrosis which is evidenced by a difference in the sizes of the two kidneys. The vast majority of patients with this condition range in age from twenty to thirty-five years. In a large series of these cases which we have examined, 30 per cent of the patients have been operated upon for appendicitis, gall-bladder disease, or ulcer without relief of symptoms.

Adhesions.—Another simular anomalous condition is occasionally found to be due to adhesions between the kidney pelvis and the upper segment of the ureter.

Horseshoe kidney is still another anomalous condition which produces obstruction (Fig. 6). The fusion of the lower poles produces a mass rather well forward in the abdomen over which the ureters must pass to enter the kidney pelvis.

This extrinsic pressure on the ureters is frequently accompanied by hydronephrosis of the accompanying kidney, with poor drainage, stasis, and in many instances renal calculi. Formerly, surgery was not undertaken for a horseshoe kidney, but recently, however, a very great deal of interesting work has been done on horseshoe kidneys and, in a very excellent monograph, Dr. Robert Gutierrez,¹ of New York, reviewed the symptoms in a large series. He chooses to call this a horseshoe kidney syndrome. It consists of (1) abdominal pain in the epigastrium or in the region of the umbilicus; (2) chronic constipation with or without gastro-intestinal disorders; and (3) urinary disturbances. The presence of a fixed mass lying over the abdominal vessels, and pressure on the solar plexus with constant irritation to



FIGURE 6

Horseshoe kidney producing obstruction of the ureter.



FIGURE 7

Duplicate ureter producing ureteral obstruction at the bifurcation.

the peritoneum due to movement and respiration, is believed by Dr. Gutierrez to be the cause of these symptoms. He recommends surgical operations upon such kidneys in order that the symptoms may be relieved.

Nephroptosis has long been thought to be a cause of ureteral obstruction, and it has been known classically for many years as *Dietl's crisis*. This was believed to be due to the angulation and torsion of the ureter by the forward and downward excursion of such a kidney. Recently, however, Smith and McKim,² of Cincinnati, have demonstrated rather conclusively that the pain which was supposed to be due to hydronephrosis is really caused by the torsion of the vascular supply of the kidney, producing either hyperemia or ischemia of the kidney,

with symptoms simulating ureteral obstruction. We believe these etiological factors should be studied and carefully considered in the presence of a ptotic kidney.

Other anomalies such as duplication of the ureters (Fig. 7) and ectopic kidneys (Fig. 8) may also produce anomalous ureters which are apt to cause either partial or complete obstruction.

Stricture of the ureter, which perhaps occurs more often in the middle or lower portion of the ureter than in the upper portion, may produce obstruction (Fig. 9). Urologists in America have not been in agreement regarding the incidence of ureteral stricture, particularly since the publication of Dr. Hunner, who believes that many such lesions occur. We are



FIGURE 8

Ureteral obstruction caused by an ectopic kidney.



FIGURE 9

Ureteral stricture producing ureteral obstruction.

inclined to believe that some of the contractures of the ureter which are relieved by catheterization may be due to spasm rather than to an actual stricture. Strictures may follow the passage of stones or other trauma to the ureter, and undoubtedly may be due to infection as is demonstrated by their frequency in the presence of tuberculosis of the kidney. If a diagnosis of stricture is to be made, the roentgen studies should be done by a series of examinations which will determine the consistency of such a contracture. This must be carried out as carefully as would a study of the consistency of a deformity of the duodenum in the presence of a duodenal ulcer. Since many mistakes may be made if only one uretrogram is made in this condition, we feel that intravenous urography determines their location very accurately and demonstrates clearly the

presence or absence of retention above the lesion.

Stones (Fig. 10) and *tumors*, both primary and secondary, may also be found in the middle and lower ureter. Secondary tumors are usually papillomas, probably having been transplanted downward from the kidney. They can generally be visualized by a urogram, thus making it possible to determine the location and extent of the resultant ureteral obstruction.

Cancer.—Primary carcinoma of the ureter is a rare lesion; yet in the few cases which we have, there has been a very definite filling defect, with a rounded lower part illustrating the extent of the tumor and the amount of obstruction which it produced (Fig. 11).

Accidental Ligation.—Ligation which may occur in the course of pelvic operations may cause obstruction. The presence of this may



FIGURE 10
Ureteral stone producing ureteral obstruction.



FIGURE 11
Ureteral obstruction caused by a primary carcinoma of the ureter.



FIGURE 12
Ureterocele at the lower end of the ureter producing ureteral obstruction.

be accurately determined by intravenous urography which will show definite nonfunctioning of the kidney on the affected side.

Much has been written about the occurrence of stricture of the lower ureter following the introduction of radium and x-ray into the pelvis for the treatment of carcinoma. We feel that no treatment of carcinoma of the ureter or adnexia should be undertaken until a urogram of the kidneys and ureters has been done to determine the dynamics of the ureter, because many of these cases are due to metastases obstructing the ureter rather than to the actual radiation.

A ureterocele at the lower end of the ureter may produce obstruction and accompanying hydronephrosis and hydro-ureter (Fig. 12). Such a diagnosis may be made by cystoscopic

examination, the ureterocele being seen to protrude into the bladder. It also may be definitely demonstrated by a well-made ureterogram.

Valves.—There is also a fairly large group of cases of congenital valves in the lower ureter (Fig. 13). These valves evidently are cup-shaped, and prevent the free passage of urine from the ureter into the bladder; however, a catheter may easily be passed into the ureter from the bladder without obstruction in many of these cases. These patients usually have had symptoms since early childhood, and have suffered for a long time before the diagnosis is determined. They complain of frequency and they are anemic. Ureteral obstruction should always be thought of under such circumstances, and the confirmation of such a suspicion may



FIGURE 13

Ureteral obstruction caused by congenital stenosis of the lower end of the ureter.



FIGURE 14

Ureteral obstruction in the lower ends of transplanted ureters.

be easily arrived at by either a pyelogram or an intravenous urogram.

Diverticula and carcinoma of the bladder are other causes of obstruction in the lower ureter. A very definite diagnosis is secured by the simple procedure of making a cystogram which will show the filling defect produced by a carcinoma, and extrinsic outpouching caused by diverticula.

Ureteral obstruction may also be due to constriction of a ureter transplanted into the bowel for bladder carcinoma or exstrophy (Fig. 14). Hydronephrosis is the result of such a complication which may be definitely determined by intravenous urography.

Pregnancy.—The presence of obstruction of the ureter during pregnancy is an interesting finding and should be carefully studied, particularly in patients with urinary infection, and

in those with severe backache. In the usual case, intravenous urography may be done every month during the pregnancy without danger to the patient, and a definite observation of the extent of hydronephrosis and damage to the kidney in many instances may be determined.

With this brief résumé of ureteral obstruction, I wish to impress the roentgenologist with the importance of the rôle he plays, and sincerely make a plea for careful study of the plain roentgen films of the urinary tract with pyelograms, ureterograms, intravenous urography, and cystograms in cases where any abnormality is suspected. This is with the hope that many of these conditions may be recognized earlier, thereby affording patients the benefit which roentgenology has to offer in this field.

LOWER URINARY TRACT OBSTRUCTION IN CHILDREN

(WITH TWO CASE REPORTS)

By SAUL J. PEARLMAN, M.D., New York, N. Y.

Read before the Passaic County Medical Society, November 22, 1938.

The perfection of the infant cystoscope by Dr. Beer in 1911, and the advent of intravenous excretion urography in 1929, by Swick, have brought about a closer coöperation between the pediatrician and the urologist, so that today many more children are being investigated than ever before. Earlier diagnosis and improved methods of therapy as a result of the newer instruments patterned upon the adult types, have widened the scope of preventative medicine, and in particular, the domain of pediatric urology.

Since congenital anomalies occur more often in the genito-urinary tract than in any other system of the body, it is not surprising, therefore, to find that obstructive lesions, resulting from these abnormalities form a great portion of the disorders of early life.

Any obstruction in the genito-urinary tract leads to that triad of 1, obstruction; 2, stasis, and 3, infection, with the secondary sequellae of back pressure, destructive changes in the kidney parenchyma, azotemia, and death; so that the early recognition and removal of these lesions is of paramount importance.

Urinary obstruction in children may be divided into two groups:

1. Upper urinary tract, or supra-vesical: This group includes any lesion above the vesical neck.

2. Lower urinary tract, or infra-vesical: This group includes all lesions below the vesical neck, including the latter.

Infra-vesical lesions manifest themselves symptomatically by alterations in the act of micturition, and are, therefore, not likely to be overlooked; whereas the supra-vesical group obstructions, especially when unilateral, may be relatively asymptomatic, and show no signs of dysfunction.

The symptoms of frequency, difficulty, tenesmus, urgency, pyuria, and haematuria are determined to a great extent by the nature and site of the obstruction, and the presence or

absence of infection. Often the haematuria occasioned by the presence of a secondary calculus, institutes a urologic survey, and brings the underlying pathology to light.

The lesions of the upper urinary tract may be briefly enumerated as: congenital valves and folds of the ureter; constriction of the ureter by aberrant vessels and fibrous band formations; strictures at the uretero-vesical and uretero-pelvic junctions; and ureterocele. Calculus, torsion, neoplasm, nephroptosis, and diverticulum represent acquired conditions.

The two cases to be presented are illustrative of a lesion in each group, but the time allotted permits a discussion only of those lesions of the second group.

Lesions in the lower urinary tract may be further subdivided into those in the *anterior* urethra, and those in the *posterior* urethra. The most common lesions in the anterior urethra are:

1. Complete atresia: an obstruction which must eventuate in death if unrelieved.

2. Strictures at the meatus: very common in both sexes, and causing extreme difficulty in urination, so that the child must strain and sometimes screams with pain at each voiding. Condition is speedily corrected by meatotomy.

3. Stenosis of prepuce, which results in phimosis or paraphimosis. Cases of long standing cause urinary stasis, infection, back pressure and finally uremia and death. These children require circumcision at birth.

4. Stricture of the anterior urethra is usually associated with strictures at the meatus, and is really a narrowing of the entire lumen. It is not comparable to the common type of submucosal infiltration that follows a Neisserian infection. Dilatations with bougies and sounds should suffice to correct this condition.

Lesions of the posterior urethra are not uncommon and give rise to clinical pictures simulating those observed in elderly victims of prostatic obstruction.

The children complain of frequency, urgency, difficulty in urination, small stream and hesitancy. At times, there may be dysuria and even haematuria. Some of these children suffer incontinence, and quite often a diagnosis of functional enuresis is made. In these cases, care and attention should be paid to the possibility of an ectopic ureteral opening, either in the vagina, or in front of the cut-off muscle. This may or may not reveal the presence of a supernumerary kidney, removal of which cures the incontinence.

Long-standing obstructions in these children result in residual urine formation, stasis, infection, renal insufficiency; and unless obstruction is removed, uremia and death follow.

The bladder will show trabeculations, and even diverticula.

The ureters are dilated, and bilateral hydro-nephrosis is present. In advanced cases, with infection super-imposed, the kidneys are destroyed and the presenting picture is that of a pyonephrosis and pyo-ureter, with azotemia.

The most common obstructions in this group are:

1. Contracture of the vesical neck: this has been emphasized as an infrequent, yet overlooked cause of obstruction in children, by the late Edwin Beer.

Accompanying this lesion are hyperplastic changes in the mucosa, muscular hypertrophy, or actual fibrosis, the exact etiology of which is unknown, since some of the cases are obviously congenital, others represent acquired infective processes; and finally a small group appear to be neurogenic, but without demonstrable nerve pathology. Urinary difficulty from birth should make one suspicious of the presence of this lesion. A ureteral catheter introduced into the bladder, after the child has voided, will encounter a definite obstruction at the neck, and will yield several ounces of residual urine. A cystogram will reveal trabeculations, diverticula, and very often reflux of one or both ureters which are markedly dilated. A method of demonstrating reflux in children is to fill the bladder with an opaque solution such as two per cent sodium iodide, and hold the child upside down by the feet for several minutes. Roentgenograms then taken in the

horizontal position will, in the presence of a reflux, show pelves and ureters well outlined. In cases of gross infection, this method has been utilized for lavage of the renal pelves, filling the bladder with various antiseptic solutions instead of pyelographic media. The obstruction is corrected either by dilatation with sounds, or failing in this, by resection, either transurethrally, or suprapubically.

2. Valves of the posterior urethra are quite common, and the lesion should be considered in cases of urinary difficulty occurring in male children. Hugh Young observed the first case cystoscopically in 1912, and removed the obstruction successfully by surgery. In 1934, Lowsley and Kerwin reported on 133 cases from the literature. In 1937, Fagerstrom collected ten additional cases, and added four of his own. The case to be presented adds another to this list.

The valves vary in size and shape. They may consist of simple folds or ridges of mucous membrane, or they may take the shape and form of definite fibrous diaphragms. There are three distinct types as reported by Young and his co-workers:

1. The valve consists of a ridge in the floor of the urethra, running from the verumontanum anterior to the bulbo-membranous urethra. Here it either divides into two processes which merge with the lateral walls of the urethra, or it completely encircles the urethra.

2. Here the valves run from the verumontanum posteriorly to the vesical neck.

3. This is the iris valve, and may be found anywhere in the posterior urethra. The diagnosis is made by cysto-urethroscopy. At the same time, the bladder will show trabeculations, diverticula, marked inflammation, and possibly calculus formation in the kidney or kidneys. Pyelography, whether retrograde or intravenous, will usually reveal bilateral dilatation of the pelvis and ureter.

The treatment is essentially the same as applied to older men suffering from prostatic disease and chronic urinary retention. The bladder must be emptied gradually and the kidneys decompressed, until the kidney function returns to normal limits. When the general condition has improved sufficiently, as evi-

denced by normal blood urea figures, normal Phthalein excretion, absence of gross infection in the urine, improved appetite, and gain of weight, the question of surgical intervention can then be considered.

Fulguration of the obstruction through the operating cystoscope, or, as in the case to be cited, resection through a suprapubic cystostomy are the procedures of choice in the removal of this lesion. It must be appreciated that in long-standing cases with this type of obstruction, treatment directed at the removal will not restore the urinary tract to its normal state. Irreparable damage has already taken place. However, it is true that clinically the patient will be greatly benefited and improved. The diverticula of the bladder, the dilated ureters and pelves may remain unchanged indefinitely. This is due to the replacement of the musculature by connective tissue fibrosis as a result of the long standing back pressure and superimposed infection. All we can hope for then, in the advanced cases, is an amelioration of their symptoms and improvement of their general condition clinically, and the prevention of added insult to the urinary tracts.

3. Cyst of the posterior urethra is rare and is merely mentioned because of a case recorded by Chase at the Royal Victoria Hospital, which he believed resulted from stenosis of Cowper's duct.

4. Hypertrophy of the verumontanum is not so uncommon. Since Bugbee and Wollstein reported eight cases from the Babies' Hospital, twenty or more cases have been added to the literature. The lesion is diagnosed by cysto-urethroscopy and corrected by shrinkage with the desiccating current.

Acute gonorrheal urethritis, urethral calculus, traumatic rupture of the urethra, neoplasm, diverticulum, etc., are acquired lesions and do not come within the scope of this presentation.

CASE NUMBER I.

L. C., female child, aged three, was admitted to the Beth Israel Hospital of Passaic on February 21, 1938, with the following:

Chief Complaints: Intermittent haematuria since the child was one year of age. During micturition the child would point in pain to her left loin. In

the interval between urination, the baby is playful, eats and sleeps well, and apparently has not lost weight. On a former admission to the hospital in June, 1937, the condition of bilateral hydronephrosis and hydro-ureter was recognized on excretion urography, but the mother signed a release refusing further treatment. When the child began to pass large clots of blood, hospitalization was again advised.



Fig. 1, Case 1—Bilateral hydro-ureter and hydronephrosis.

Past History: Essentially negative.

Physical Examination: On admission, revealed a well-nourished, white, female child who did not appear to be acutely ill, and with nothing remarkable as to her general physical status. Excretion urography showed a bilateral hydronephrosis and hydro-ureters, and a calculus in the lower end of the left ureter.

Cystoscopy: Inhalation anesthesia.

No evidence of bladder trabeculation, or deformity, fibrosis, or stenosis at the vesical neck. The bladder efflux was hazy, and the left ureteral mouth was pouting, a beginning ureterocele. The right ureteral mouth, while small, appears normal. A French No. four catheter was introduced up each ureter, aspiration yielding two c.c. of retained urine



Fig. 2, Case 1—One year later. Insufficient filling of pelvis and ureters, and showing the addition of a left ureteral calculus.



Fig. 3, Case 1—Excretion urogram, six months post-operatively, showing marked reduction in size of pelvis and ureters.

from each pelvis. On microscopy, the bladder efflux showed masses of RBC and five WBC to the high-powered field. The left urinary efflux showed 25 RBC to each field with an occasional WBC. All effluxes were negative for organisms on culture. Haemoglobin was 97 per cent, RBC 5,200,000, WBC 10,000, Polys. 80 per cent, Lymph. 18 per cent, Monos two per cent.

Pre-operative Diagnosis: Bilateral hydro-ureter, and hydronephrosis due to the congenital strictures at the uretero-vesical junctions, and a left ureteral calculus.

Operation: Four days after admission, February 25; inhalation anesthesia. Immediately prior to operation, the child was subjected to cystoscopy and a French number four catheter was passed up each ureter and allowed to remain in situ. Midline supra-pubic incision was now made. Bladder mobilized and opened. One ureteral catheter was accidentally cut with scissors in opening the bladder and this end was brought out to the surface. Both ureteral mouths were now incised for about one inch in an upward direction, and the edges treated with the Davis-Bovie coagulating current. The lower end of the left ureter was then brought into the field of operation by blunt finger dissection, and

an attempt was made to milk the calculus into the bladder. The enormous dilatation of the ureter with the calculus slipping up and down its interior, the depth and smallness of the wound as compared with the examining hand, rendered this attempt ineffectual. Fearing to subject the child to added undue shock, it was deemed advisable to discontinue further efforts to extract the calculus in the hope that it might pass spontaneously through the enlarged uretero-vesical junction. The bladder was sutured around an in-dwelling French number 20 catheter and the distal end of the catheter was sutured to each labia by means of a rubber cuff attachment. A rubber dam was placed in the space of Retzius and the wound was closed in layers.

Convalescence: Rather uneventful, and wound healing was slightly interrupted by the presence of a stitch abscess at the lower angle. When repeated roentgenograms failed to show descent of the calculus into the bladder, probably the result of lack of expulsive power in the atonic dilated ureters, it was decided to remove the calculus surgically. Accordingly, on March 25, almost four weeks later, the child was subjected to a uretero-lithotomy through a lumbar incision under inhalation anesthesia.

Convalescence: Interrupted twelve hours post-operatively, by the appearance of what seemed to be a collapse of the entire upper lobe of the right lung, which was attributed to a plugging of the bronchus with mucus. Her condition in a few hours became so acutely critical that we despaired of her life, and left her receiving the last rites, feeling that it was a question of minutes only. But with dramatic suddenness, the clinical picture changed, from what appeared to be a certain exitus to that of a smiling, easily-breathing child. In all probability, the plug of mucus obstructing the bronchus had been dislodged, allowing reentry of air into the collapsed lung. The desperate fight that this child made for her life is a picture to be long remembered.

One month after her discharge from the hospital she was subjected to a cystoscopy, and two French number four catheters were successfully introduced through each ureter mouth. Urography indicated a diminution in the size of both pelves and ureters, and this time, we recovered the bacillus coli on culture from all urinary effluxes. On September 12, six months post-operatively, despite Mandelic acid therapy, the left urinary efflux was still positive for bacillus coli. At this time, pyelo-ureterograms showed a still further decrease in size of the both pelves and ureters.

CASE II.

A. P., white male child, aged nine, recently arrived from Italy, was admitted to the Beth Israel Hospital in Passaic on September 27, 1937, with the following:

Chief Complaints: Pain in the left lumbar region for the past two weeks, haematuria, frequency of urination.

Present Illness: Had haematuria in 1933 which lasted for about three months, and was intermittent, after which he felt well until 1935, when he suffered a recurrence of the haematuria which lasted fully six months. This was followed by another attack two months prior to admission.

Past History: Was a seven months' premature baby at birth. At the age of three months had an attack of convulsions and hyper-prexia of unknown origin.

Physical examination revealed an undernourished, anemic child, with a slightly rachitic chest, and slight tenderness on fist percussion of the left kidney area. Excretion urograms showed a hydro-nephrosis of the left kidney, and a fairly large-sized calculus apparently impacted at the lower end of the left ureter. In addition, there was a definite obstruction in the deep urethra which did not admit a French number 8, 6, 5, 4 catheter, nor even a filiform bougie—in all probability, a congenital valve formation, or diaphragm. The strange and peculiar part of this case is that with an obstruction in this region, the right kidney pelvis and ureter seemed to have escaped the damaging effects of back pressure. The dilatation of the ureter and pelvis limited to only one side of the urinary tract is indeed unique. Evidently the back pressure exerted in this case failed to overcome the competency of the uretero-vesical valve on the right side. An attempt

was now made to introduce a baby cystoscope, but this, likewise, could not overcome the obstruction. A comparison of the roentgenograms with those taken in Italy several months ago shows the calculus to have increased in size. Surgical intervention was advised.

Pre-operative Diagnosis: 1, Impacted calculus in the lower end of the left ureter, with hydronephrosis of the left kidney above. 2, Urethral obstruction due to a congenital valve or diaphragm.



Fig. 4, Case 2—Excretion urogram showing left hydro-nephrosis, hydro-ureter, and left ureteral calculus.

Operation and Findings: September 30, 1937; inhalation anesthesia.

1. A large calculus, spiculated and embedded in the lower end of the ureter, just above the ureterovesical junction.

2. An obstruction in the deep urethra which could not be overcome either via the urethra, or retrograde via the internal sphincter.

Operation: Median supra-pubic incision extending from the symphysis to left of the umbilicus. The peritoneum was reflected from the bladder, and then the parietal peritoneum was pushed away by finger dissection toward the median line, exposing the lower end of the ureter. The latter was incised directly over the calculus, and the calculus removed.

A Levin duodenal tube was now passed up the ureter to the pelvis, and this was followed by a gush of urine which was collected and sent to the laboratory. The bladder was now opened with electro-surgical knife, and using a cervical conization electrode passed into the deep urethra via the internal sphincter, the obstruction was resected. A French number twelve silk-woven catheter was now introduced through the urethra into the bladder, and sutured to a French number ten soft rubber urethral catheter. The latter was now withdrawn and anchored with silk-sutures by means of a rubber cuff attachment to the prepuce. The bladder was now closed around a supra-pubic tube, with two rows of plain 0 catgut. The first row of sutures approximating the outer and muscular coats, the second row burying the first simply approximating the outer coats. A rubber dam drain was placed down to the opening in the ureter, and another in the space of Retzius, and the wound was closed in layers. In pulling off the drapes, at the completion of the operation, the assistant inadvertently pulled out the indwelling urethral catheter—and although attempts were made to reintroduce it, it was felt that the catheter had not entered the bladder (edema after recent resection). Rather than subject the patient to added shock, it was decided to adopt a watchful waiting attitude.

Fourth Post-operative Day: Indigo-carmin injected intravenously appeared from the bladder efflux in twenty-five minutes, and from the left kidney efflux via the in-dwelling duodenal tube in twenty-seven minutes, with good concentration on both sides.

Eighth Post-operative Day: The Levin tube was removed from the left ureter. There was a balanoposthitis present.

Twelfth Post-operative Day: A superficial abscess in the midportion of the supra-pubic wound was incised and drained.

Seventeenth Post-operative Day: Temperature rose to 104.8. Supra-pubic drainage was poor. The supra-pubic tube and the in-dwelling urethral catheter were now withdrawn, and an attempt was made to reintroduce the urethral catheter, but this was unsuccessful, the catheter meeting an obstruction in the deep urethra. Five hours later the patient voided spontaneously for the first time, seventeen days post-operatively, and the temperature receded sharply.

Twenty-second Post-operative Day: A dorsal slit incision was necessary on account of the marked edema of the prepuce.

Twenty-eighth Post-operative Day: Patient dis-

charged. The sinus closed, the patient was voiding normally, and the parents were instructed to bring the child to the office for urethral dilatations. Unfortunately, the parents failed to cooperate in this respect, so that we are unable to furnish a detailed follow-up study, although the father, in a personal communication, informed us that the boy was doing well, gaining weight and voiding with a good, forceful stream.

Pathological Report: Resected specimen consists of a somewhat vascular fibro-muscular tissue, the lining of which shows a coagulative necrosis. Situated within the fibro-muscular element are several well-defined glands, the lining of which is high columnar with some capillary hyperplasia within the lumen.

The culture of the urine from the left kidney showed gram-positive cocci, but this was negative on a second culture, and in the absence of gross infection, this was interpreted as a contamination.

SUMMARY AND CONCLUSIONS

1. Obstructive lesions in the urinary tract of children are usually congenital, resulting from anomalous development.
2. Obstructions in children are found both in the upper and lower urinary tracts.
3. A case of obstruction in each of the upper and lower urinary tracts has been presented, with successful removal of the offending obstruction by surgery.
4. All children with pyuria should have a complete urologic investigation. The administration of Mandelic acid is valueless unless the obstruction is removed.
5. The importance of early recognition and treatment of urinary obstruction is stressed.
6. Treatment of urinary obstruction must be carried out before advanced destructive changes to the genito-urinary tract have taken place.
7. The more common obstructive lesions of the lower urinary tract in children are briefly discussed.

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PATHOLOGY AND TREATMENT OF URINARY INFECTIONS IN CHILDREN

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No rational treatment of urinary infection omits serious consideration of the pathogenesis and pathology of the disease. These last two considerations are so important that the major portion of the present discussion will be concerned with the variety of changes which may occur in the urinary tract of patients with urinary infection. The clinically convenient diagnosis of pyelitis which is almost universally made upon the demonstration of pyuria at once suggests that the clinician lacks an adequate conception of the probable underlying pathology in the presenting disease. The popular conception of the condition which clinicians loosely designate as pyelitis is, as the term indicates, solely an inflammation of the kidney pelvis. Yet lesions in the parenchyma consequent to the infection are of infinitely greater importance. Only with a reasonably clear understanding of these changes and of their direct and accessory causes can we hope intelligently to treat urinary infection in patients of any age. Although the newer antiseptics are of great interest and value, my present aim is more to direct attention to the variety of renal changes in urinary infection, knowledge of which will at once explain the frequent failure of chemotherapy.

Occasionally infection is limited to the lower urinary tract, but as a rule the initial and important lesion is in the kidney. In the present communication only renal infections will be considered.

PATHOGENESIS

Etiology, Bacteria.—Renal infections can be conveniently clinically divided into the non-tuberculous and tuberculous varieties. There are a few unusual renal infections such as actinomycosis, blastomycosis, and parasitic invasions which together with tuberculosis will be omitted from the present discussion.

The non-tuberculous bacterial invaders of the kidney may be subdivided according to their Gram stain characteristics. In the older literature it was commonly stated that 90 to 100 per cent of renal infections in infants and children were caused by the Gram negative bacilli of the colon-typhoid group, and notably *B. coli communis*. More recent studies have shown that the incidence of Gram positive cocci, particularly staphylococci, is extremely high, and especially early in the course of the disease. Catheterized specimens taken during the first thirty-six hours of the manifest clinical disease will show Gram positive cocci in at least 40 per cent of the cases. Catheterized specimens taken after a week in these cases will show a surprisingly high incidence of *B. coli*; and in cases of mixed infection, *B. coli* and staphylococci most often coexist. This observation has led to the theory of dual renal infection: the invading Gram positive cocci are assumed to enter the kidney, and by renal injury to produce a fertile field for subsequent bacillary invasion and development. This theory has not been generally accepted despite frequent clinical observations suggesting its validity. The invading bacteria in 381 cases of acute and 580 cases of chronic urinary infection in children are shown in Table I. (See p. 224.)

ETIOLOGY, ACCESSORY FACTORS

Urinary stasis, or urinary constipation, is the outstanding accessory or predisposing cause of urinary infection. The stasis usually results from obstruction; yet in some instances it is due to neuromuscular inertia consequent to neuromuscular disease of the urinary tract. In the young the last is most commonly associated with congenital malformations of the spine and lower central nervous system. Most urologic obstructions in infants and children are con-

genital, and as shown in Figure I may exist at any point from a tight prepuce to a narrowed renal calyx. Ureteral obstructions are of highest incidence, but are only of slightly more frequent occurrence than urethral obstructions, particularly in its posterior segment and at the vesical outlet. Of ureteral obstructions, congenital stricture is encountered most frequently, the order of incidence being at the ureterovesical junction, at the ureteropelvic junction, and in the body of the ureter. Obstructions in the urethra include congenital stricture and congenital contracture of the bladder neck in both sexes, and in addition in the male, congenital valvular obstruction of the posterior urethra and congenital hypertrophy of the verumontanum.

The manner in which urinary obstruction operates as an etiological accessory in renal infection is as follows: The structures above the point of obstruction become congested as a result of the urinary stasis or backpressure; the congested organ becomes a *locus minoris resistentiae*. Bacteria are continually reaching the kidney by the blood stream, but normally are destroyed by the rich endothelial cellular deposit of the capillary bed. In the congested organ whose bacterial defenses are reduced by congestion, bacterial invasions which ordinarily would be destroyed gain a foothold, and infection develops. It is therefore axiomatic that urinary obstruction predisposes to infection; once infection is established in the presence of obstruction it is extremely difficult to sterilize the urine without removing the cause of the urinary stasis. Until the advent of ketogenic diet therapy, its successor—mandelic acid therapy, and finally sulphanilamide, it was practically impossible to sterilize the urine in the presence of obstruction.

Urinary obstruction and stasis are so commonly important accessory etiological agents that one can scarcely intelligently undertake the treatment of urinary infection without giving the potential mechanical factors prime consideration. This is observed, for example, in the patient with so-called persistent acute pyelitis. Here urological examination usually reveals an infected hydronephrosis and with the establishment of free drainage the temperature

generally comes to normal. Urinary stasis is the important accessory etiologic lesion in over 90 per cent of young patients with persistent urinary infection, i. e., the children treated months and years for "chronic pyelitis". In the majority of these cases eradication of the stasis is promptly rewarded by striking clinical improvement, and the combined application of this treatment and intensive oral chemotherapy will bring about urinary sterilization in three out of four cases.

ROUTE OF INVASION

The bacterial invasion in renal infection is usually hematogenous, or descending. Ascending infections are doubtless of higher incidence and greater importance than heretofore appreciated; but recent experimental observations strongly indicate that in ascending spread the bacteria reach the kidney by a combined lymphohematogenous route rather than by direct urogenous extension through the ureteral lumen or by direct upward extension through the periureteral lymphatics. Winsbury-White, for example, points out that bacteria absorbed from pelvic and genital foci reach the regional upper pelvic nodes (hypogastric) and thence pass upward along the lumbar lymphatic chain to join renal peripelvic lymphatics and through this communication reach the kidney. Yet the likelihood is equally great that bacteria absorbed into the hypogastric and other pelvic regional nodes eventually reach the thoracic duct, and through it the general circulation, with hematogenous invasion of the kidney. Since renal infection is always secondary to infectious foci elsewhere, recognition of these various routes of invasion and eradication of these foci are necessarily important phases of rational therapy.

PATHOLOGY

The experimental work of Helmholtz has shown that after forty-eight hours it is impossible to determine histologically whether the bacterial invasion was hematogenous and began in the parenchyma, or was ascending and began in the renal pelvis. In other words, pelvic infection promptly spreads to the parenchyma, and vice versa. For this reason, in the human

TABLE I *

BACTERIOLOGY OF THE URINE IN URINARY INFECTION IN 961 CHILDREN

	<i>Acute</i> (381 Cases)	<i>Chronic</i> (580 Cases)	+	(381 Cases) + (580 Cases) = 961
<i>B. coli</i>	63	368		
Communiior	8			
Communis	22			
<i>Staphylococci</i>	10	143		
<i>S. albus</i>	1	66		
<i>S. albus hemolyticus</i>		12		
<i>S. aureus</i>	2	23		
<i>S. aureus hemolyticus</i>		9		
		—		253
<i>Streptococci</i>	6	34		
Hemolyticus		19		
Non-hemolytic	5	11		
Viridans		13		
		—		77
<i>Pneumococcus</i>	2			
<i>B. proteus</i>		20		
<i>B. pyocyaneus</i>	2			
<i>B. typhosus</i>		13		
<i>B. paratyphosus</i>	4	2		
A	1			
B	1			
<i>B. intermediate</i>		11		
<i>Tubercle bacillus</i>		8		
<i>Gram positive bacillus</i>		16		
<i>Gram negative diplococcus</i>	1			
<i>Diphtheroids</i>		10		
<i>Enterococcus</i>	1	5		
<i>Dysentery bacillus (Flexner)</i>		6		
<i>Dysentery bacillus (Rosen)</i>	1			
<i>Micrococcus tetragenus</i>	1	3		
<i>B. aerogenes capsulatus</i>		1		
<i>B. acidilactici</i>	2			
<i>Mixed infection</i>	25	136		
<i>Bacteria seen, no culture</i>	2			
<i>No growth</i>	6	44		
<i>Not recorded</i>	244	26		

* The statistical data in Tables I, IV and V and Figures 1 and 2 are from the author's book, "Pediatric Urology", Macmillan Co., New York, 1937.

EXPLANATION OF FIGURE I ON THE FACING PAGE

FIGURE 1

Causes (direct and indirect) of pyuria; these are predominantly obstructive: 1, Stenosis of prepuce; 2, stenosis of urethral meatus; 3, paraphimosis; 4, urethral stricture; 5, urethral stone; 6, urethral diverticulum; 7, periurethritis; periurethral abscess; 8, cowperitis; chronic external spincterospasm; 9, congenital valves of posterior urethra; 10, hypertrophy of verumontanum; verumontanitis; 11, prostatitis, prostatic abscess; 12, contracted bladder neck; median bar; 13, periprostatitis or pelvic suppuration; 14, mucosal fold at bladder outlet, trigonal curtain; 15, stricture of ureteral meatus; ureterocele; 16, ureterovesical junction stricture; 17, vascular obstruction of lower ureter; 18, congenital ureteral valves; 19, ureteral obstruction by diverticulum compression; 19¹, diverticulum; 20, ureteral stone; 21, ureteral stricture; 22,

periureteritis; periureteral phlegmon or abscess; 23, ureteral kink; perireteral fibrous bands; 24, renal tumor; 25, ureteropelvic junction stricture; 26, aberrant vessel (obstruction of upper ureter); 27, pelvic stone; 28, renal tuberculosis; 29, stricture of calyceal outlet; 30, calyceal stone; 31, pyelonephritis; 32, pyonephrosis; 33, "pyelitis"; infected hydronephrosis; 34, perirenal suppuration invading urinary tract; spinal disease (Pott's, etc.); 35, hydroureter; 36, pericystic abscess rupturing into bladder; 37, seminal vesiculitis; 38, neuromuscular vesical disease; 38¹, cystitis; 39, urethritis; 40, folliculitis (Littre); 40¹, folliculitis (Morgagni); 41, periurethritis; periurethral abscess; 42, endometritis; 43, cervicitis; 44, foreign body in vagina; 45, vaginitis; 46, skenitis; 47, folliculitis of introitus; 48, Bartholinitis.

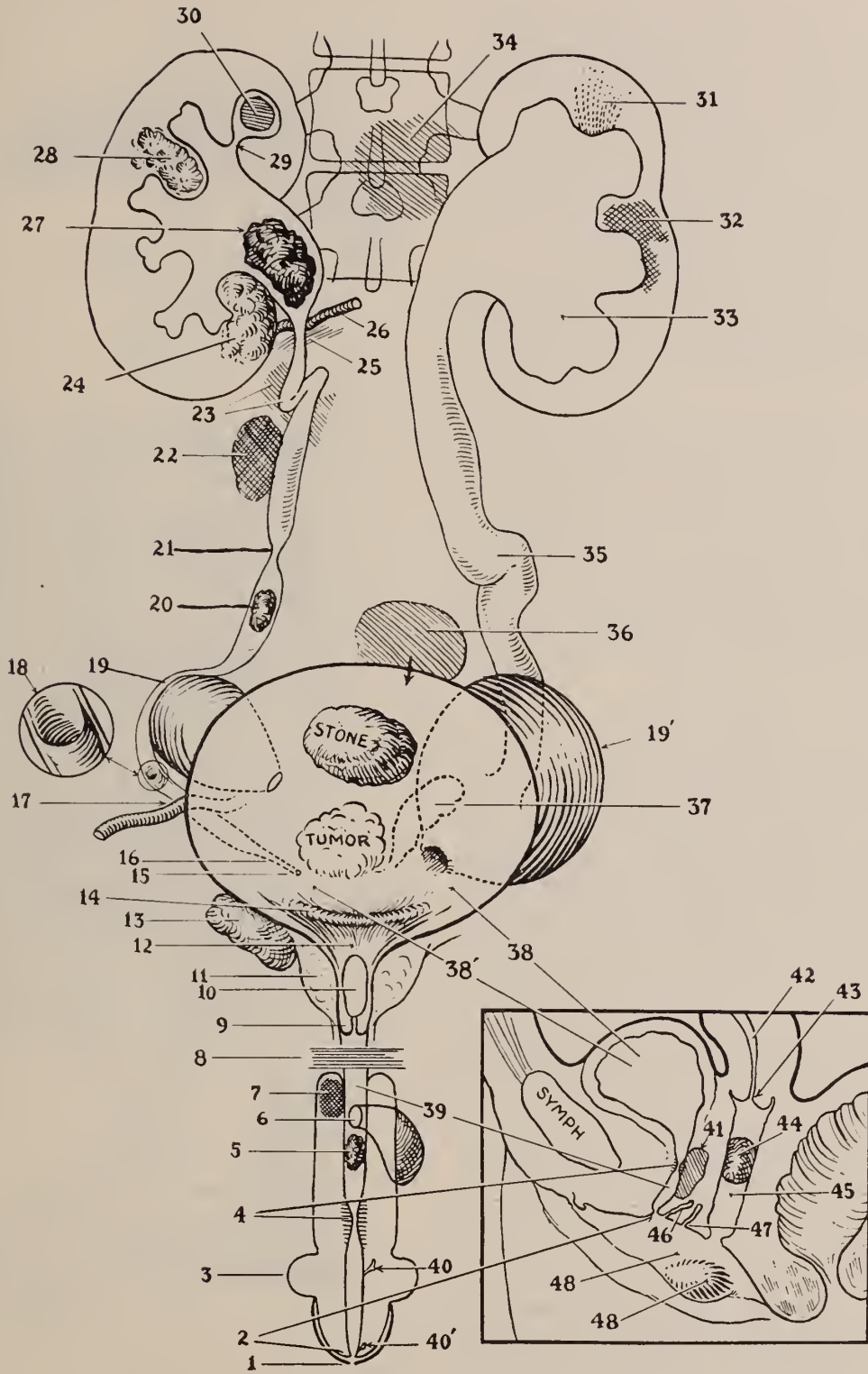


FIGURE 1
CAUSES OF PYURIA
(For explanation, see the facing page.)

EXPLANATION OF FIGURE 2

Schema of renal infection. Routes of invasion of the renal parenchyma. 1.2. Hematogenous. A.A., arcuate artery giving off interlobar branches (1) which ultimately pass to the glomeruli as the afferent glomerular arteries (Af. gl.). Leaving the glomeruli, the efferent glomerular vessels (Ef. gl.) pass downward as nutrient vessels of the parenchyma, ultimately to become large veins (2) and finally empty into the arcuate vein (A. V.). Retrograde extension of bacteria by pyelovenous back-flow from the pelvis may also occur.

3. Lymphogenous. Through lymphatics of the pelvis, or those which surround the arteries and collecting tubules (Kumita), or those which penetrate the renal capsule (R. C.) from the perirenal fat. H. N., hilar lymph node; A. N., aortic lymph node.

4. Intratubular. Spread by retrograde extension (reflux) through the tubules from the pelvis. Experimentally this is difficult to produce and doubtless the pathway is seldom of clinical importance.

5. Extension from the pelvis by vascular thrombosis. Helmholtz in particular has emphasized the importance of this process.

6. By rupture through the pelvis with direct intertubular (interstitial) extension or extravasation. This is probably rare. Bacterial invasion of the kidney by irruption from neighboring foci or by surgical attack is not indicated.

Pathologic sequence of infection:

A. Bacterial embolism in interlobular arteriole a, interlobular efferent vessel a', glomerular arteriole a" or lymphatic vessel a'''.

B. Early cellular reaction to the bacterial invasion. Note that the lesion is at first limited to the interstitial spaces of the kidney and the initial reaction is a perivascular leucocytic infiltration. Cloudy swelling (Cl. Sw.) of the epithelial cells of the adjacent tubules occurs. Symptoms are probably uncommon at this stage.

C. An advanced stage of B. leucocytic infiltration and cloudy swelling increases; polymorphonuclears, lymphocytes, plasma cells and large mononuclears are the cells regularly found. Histosections of this stage frequently show polymorphonuclears extruding their way between the swollen epithelial cells into the lumen of the tubules.

D. Late stage of C with massive focal suppuration. Vascular thrombosis, extensive leucocytic infiltration, destruction of the adjacent tubules (Dg. Ep., degenerated epithelium) with discharge of the purulent debris into the collecting tubules and thence into the pelvis.

The above schema indicates why, in so-called pyelitis, the interstitial lesion is so much more important than any mere inflammation of the pelvis. It also demonstrates how most of the pus found in the urine in these cases originates in the interstitial lesions rather than in areas of mucosal inflammation.

C. T., convoluted tubule. Pr. C. T., proximal convoluted tubule.

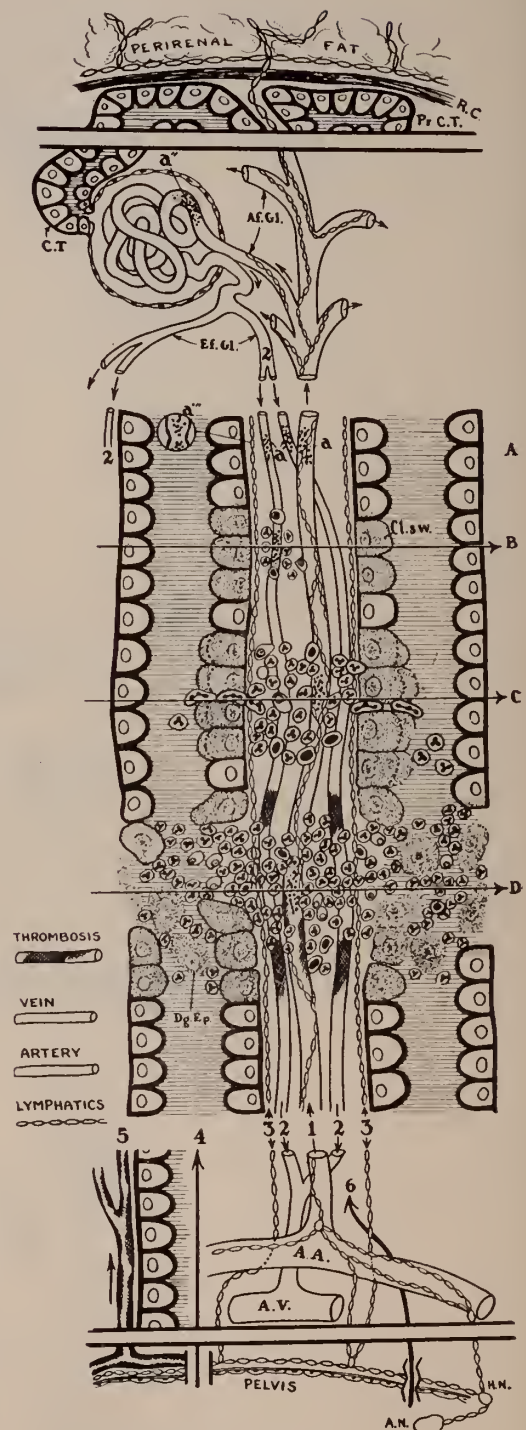


FIGURE 2

Routes of invasion of infection into the renal parenchyma.

the anatomic diagnosis should be pyelonephritis with emphasis on the nephritis. It has been shown that the important initial lesion is bacterial embolism in the vascular tree in the interstitial tissue of the kidney. This is schematically indicated in Figure two, where it is shown that the vessels passing to and from the glomerulus, as well as the collateral lymphatic structures, course in the interstitial spaces between the convoluted and collecting renal tubules. The bacterial embolus may be minute (A) and disappear without scarring or other microscopic evidence. Doubtless such bacterial invasions are continually recurring normally. If the invasion is more virulent or the local resistance is diminished, perivascular infiltration of varying degree occurs. With moderate bacterial activity there is cloudy swelling of the adjacent epithelial cells lining the renal tubules (B) (C). The fundamental lesion in most cases of so-called acute pyelitis is, therefore, an interstitial suppurative pyelonephritis. As the process advances, perivascular leucocytic infiltration becomes more pronounced, there is greater cloudy swelling of the epithelial cells; and in serial section study, polymorphonuclear leucocytes can be seen extruding themselves between the injured epithelial cells into the lumen of the collecting tubules (C). It is these leucocytes that constitute the bulk of the pus found in the urine in renal infection. In other words, the pyuria originates in the interstitial suppurative lesions of the parenchyma, and pyuria consequent to pelvic inflammation per se (pyelitis) is negligible.

As the interstitial infectious process becomes still more marked, there is desquamation of the epithelial cells of the adjacent tubules and irruption of the interstitial suppurative mass occurs into the tubular lumen (D). The next stage is macroscopic renal abscess. Helmholz has stressed the importance of thrombosis in the spread of infection within the kidney.

The lesions just described heal by sclerosis, with loss of function of the collecting tubules occluded by the reparative scar, and atrophy of the glomeruli dependent upon the occluded tubule for drainage. When it is appreciated that in the usual hematogenous renal infection the processes above described are generally universal throughout the kidney, and are commonly

bilateral, the vast amount of renal damage which may occur in so-called acute pyelitis is readily apparent. Upon microscopic examination of such kidneys, one can only marvel that the renal function, as indicated by laboratory criteria, remains comparatively as good as it is usually found to be after a severe attack of renal infection. Moreover, the relative inaccessibility of the interstitial suppurative lesions at once explains the frequent failure of chemotherapy in these cases. The necessity for free urinary drainage and for reliance on the patient's own defensive mechanism to kill the bacteria in the deep parenchymal lesions is at once apparent.

Sometimes the renal defense is poor, or the invading organisms are unusually virulent. *Massive focal suppuration* of the kidney ensues; and if it is demonstrated to be unilateral, nephrectomy offers the only hope to save life. When the process is bilateral the prognosis is usually hopeless despite early attempts to establish cortical drainage by decapsulation and by this procedure also to improve the renal blood flow.

CASE REPORT

An eight-year-old girl was admitted to the hospital with the diagnosis meningitis which was later changed to "acute pyelitis". Meningismus resulted from toxemia of a persistent hyperacute right renal infection. Urologic examination suggested the diagnosis of right renal carbuncle, but nephrectomy disclosed massive focal staphylococcal suppurative nephritis—metastatic from a furuncle of the knee. The child's life was saved only by (1) prompt recognition that the "acute pyelitis" was a desperate surgical condition; and (2) immediate surgical therapy.

In some instances the hematogenous metastatic bacterial invasion is massive and localized, involving one or more of the larger branches of the intrarenal vascular tree. Such processes give rise to more or less triangular areas of embolic suppuration; and with the formation of abscess the designation of *renal carbuncle* is frequently given. This metastatic renal lesion occurs particularly with focal infections of the skin and skeleton. It was discovered at operation in a nine-year-old girl who had been treated for a month for "persistent acute pyelitis". Nephrectomy saved her life.

Infection of an obstructed kidney produces *infected hydronephrosis*. Here renal destruc-

tion is rapid because of (1) urinary backpressure, and (2) diminished renal resistance brought about by hydronephrotic injury. Unless free drainage is established promptly, massive renal suppuration will demand nephrectomy—or the child may die.

Occasionally the parenchymal infection extends to the perirenal fat and causes *perinephritis* which is frequently self-limited, but on occasion progresses to *perirenal abscess*. Unfortunately the clinical picture commonly causes the diagnosis of “persistent acute pyelitis” to be made, and medical therapy to be employed both persistently and fruitlessly. With abscess formation, early recognition and adequate drainage of the suppurative lesion are imperative; yet the mortality of properly treated cases is 20 per cent.

In the foregoing discussion we have briefly indicated the pathologic types of renal infection commonly encountered. Of these *interstitial suppurative pyelonephritis* is by far the most frequent lesion causing “pyelitis”. Yet these conditions may all produce the same clinical picture, and can be diagnostically differentiated only by thorough urologic investigation; or, at times, by surgical exploration. Moreover, each demands a different therapy. The frequent failure of chemotherapy is thus readily explained. Moreover, in many instances of acute renal infection, accessory or complicating lesions induce a persistence of the infection which can be eradicated only by urosurgical methods, or combined urosurgical methods and vigorous antisepsis.

TREATMENT OF ACUTE INFECTION

The treatment of acute urinary infection in children may be outlined as follows:

Bed Treatment.—The child should be kept in bed until the temperature has been normal for forty-eight hours. If activity after this period is followed by recurrence of temperature, he should again be put to bed. During the period in bed, quiet, rest and proper hygienic conditions in the sick room are assumed. The writer recognizes no special diet for this period; as the illness subsides, the appetite will return. Maintenance of nutrition and the combat of dehydration and acidosis—especially in infants—are the major considerations.

Water is the best medicine during the acute period, and the addition of glucose up to ten per cent not only affords nutrition, but greatly aids in the combat of acidosis. It is notable that the most alarming symptoms in acute renal infection in children are ascribable to the accompanying acidosis. The fluid intake may be administered by mouth, by hypodermoclysis, by intravenous infusion, or by intraperitoneal injection according to necessity and facility. If there is excessive vomiting, one must guard against alkalosis through excessive loss of hydrochloric acid.

Detoxication of the Patient.—This implies adequate laxation, and in older children, particularly, the twice-daily employment of voluminous colonic irrigations. These are not given with the motive of voluminous fecal return, but rather to bring about the elimination in solution of large quantities of toxic material, and the absorption from the bowel of a moderate amount of fluid. As the patient's condition improves, the colonic irrigations are reduced to one a day, and then one every other day.

Diuresis and the combat of acidosis or alkalosis have been briefly mentioned under confinement to bed.

Eradication of Focal Infection.—Whenever the probable primary focus can be identified, its prompt eradication is indicated. The importance of this has been considered under etiology.

Chemotherapy.—Alkalinization of the urine per se has no bacteriocidal value. The coincident alkalinization of the patient, however, helps to combat acidosis, and commonly causes a striking improvement in the child's general condition; yet the urine shows no improvement. It is solely to combat acidosis that we advocate the liberal employment of chemical alkalinization (soda bicarbonate, potassium citrate, etc.) in acute urinary infection in children. This is given in conjunction with large amounts of carbohydrate, particularly glucose or sucrose. The last is a better diuretic.

Acidification of the urine of sufficient degree to kill bacteria is irrational therapy in acute renal infection. Moreover, the alteration or switching of the urine titre from acid to alkaline and vice versa is empiric and valueless.

While the child is acutely ill, and perhaps is even vomiting, his alimentation is seriously de-
ranged, and all urinary antiseptics should be
withheld. In my practice I prefer to withhold
all medication (except soda bicarbonate) until
digestion is reestablished; by this time the
temperature is usually near normal. I have
seen many children acutely ill seriously handi-
capped by the premature administration of

or perirenal suppuration will be found. Free
urinary drainage can usually be established by
the passage of a catheter to the pelvis, to the
ureter, or to the bladder, according to the point
of obstruction. Occasionally the catheter must
be fastened indwelling for a variable period—
until the anatomic diagnosis is established, and
the necessity for surgical treatment is deter-
mined.

TABLE II
MANDELIC ACID THERAPY

<i>Dose</i>	<i>Children</i>	<i>Common Bacteria Affected</i>
Grams in 24 hrs.	1-24 mos. 2- 4	Gram neg. bacilli
	2- 4 yrs. 4- 6	(B. coli, aerobacter typhoid)
	5- 8 yrs. 5- 8	Staphylococcus
	9-12 yrs. 8-12	Streptococcus fecalis (entero- coccus)
		Pyocyaneus (pseudomonas)
		Proteus (if acid)
Fluid Intake: Restrict only with caution		
Urine Reaction: Must be more acid than pH 5.5		
Mandelic acid concentration greater than .5%		
Ammonium chloride, calcium chloride, ammonium nitrate q.s.		
pH Test: Nitrazine, chlorphenyl red, potentiometer		

TABLE III
SULPHANILAMIDE THERAPY

<i>Dose</i>	<i>Children</i>	<i>Bacteria Affected</i>
Grains in 24 hrs.	Under 2 yrs. .. 5-10	B. coli; B. aerobacter
	2- 4 yrs. 10-20	Staphy. aureus
	5- 8 yrs. 15-25	Strep. hemolytic B.
	9-12 yrs. 20-35	Proteus
		Pyocyaneus (pseudomonas)
Fluid Intake: Restrict only with caution		
Urine Reaction: Preferably alkaline: Coadminister sodium bicarbonate q.s.		

urinary antiseptics. When the child can toler-
ate medication, a mandelic acid compound, or
sulphanilamide, may be given in the indicated
doses, but should be stopped at once if they
cause intestinal disturbances. It is logical to
give the child a few days in which to regain
his digestive equilibrium; and having accom-
plished this, urinary atisepsis can then be prop-
erly and more effectively administered in large
doses.

Drainage.—If the patient with evident acute
renal infection shows no improvement during
five days of conservative medical therapy by
the method suggested, a complete urologic ex-
amination is indicated. Such an examination
will demonstrate faulty urinary drainage in
most instances; but in some cases massive renal

In a child of eight weeks with persistent acute
pyelonephritis, urologic examination revealed a con-
genital stricture at the ureteropelvic junction with
infected hydronephrosis (Flexner dysentery bacil-
lus). The establishment of free drainage by the
passage of a ureteral catheter was promptly fol-
lowed by a decline of the temperature to normal.

Indwelling catheter drainage of the bladder
may be temporarily required when congenital
vesical outlet obstruction is complicated by
acute renal infection. When the urologic ex-
amination reveals perirenal abscess, advanced
infected hydronephrosis, acute diffuse massive
renal suppuration, renal carbuncle, or pyone-
phrosis, incision and drainage or nephrectomy
respectively offer the only hope to save life.

Most acute renal infections are self-limited
despite therapy. Yet no patient with urinary

infection should be discharged as cured until at least two sterile cultures of a catheterized specimen have been obtained. When the infection persists more than four to six weeks despite intensive medical therapy, a complete urologic examination is indicated. Intelligent treatment of chronic urinary infection therefore demands an accurate diagnosis. Even though the urine is sterilized by mandelic acid, or sulphanilamide in cases of persistent pyuria, the very chronicity of the infection strongly suggests urinary stasis. Therefore, despite successful chemotherapy, it is strongly urged that these children be given the benefit of an excretory urographic study to make sure that urinary obstruction does not exist. As a therapeutic corollary, if one can sterilize the urine by methenamine therapy, it may be assumed that important urinary obstruction is not present.

TREATMENT OF CHRONIC INFECTION

In the treatment of chronic urinary infection in children a large fluid intake is important. Constipation must be actively combatted. Every effort should be bent to improve the child's nutrition, and as far as possible focal

infections should be eradicated. Unfortunately, these therapeutic fundamentals are too frequently overlooked in the rush for chemotherapy.

Until the advent of ketogenic diet therapy methenamine and ammonium chloride in large doses constituted our most effective urinary chemotherapy. Mandelic acid therapy, which is the direct descendent of ketogenic diet therapy, is doubtless our safest effective urinary antiseptic at the present time. Sulphanilamide is used extensively by the writer, but must ever be considered a dangerous drug.

In employing both mandelic acid and sulphanilamide, the strict bacteriologic indications for their use must be observed. As a result of unwarranted publications and much unfounded sales talk, these antiseptics have been widely and fruitlessly employed in infections in which they are not and cannot be expected to be of aid (see Tables II and III). In general, and observing bacteriologic indications, it is my practice first to employ ammonium manadate in large doses; and if this is not successful, to use sulphanilamide. Although patients taking each medication should be under careful sur-

TABLE IV

CHRONIC URINARY INFECTION IN 580 CHILDREN: AUTHOR'S SERIES
UROLOGICAL EXAMINATION—PYELOGRAPHIC FINDINGS

	Right	Left	Bilateral	Total
Normal pyelograms				201
Dilatation of one calyx	3	3		6
Hydronephrosis	57	35	36	128
Pyelonephritis	7	8	41	56
Pyonephrosis	13	9		22
Hemi-pyonephrosis (reduplicated kidney)	7	4		11
Renal tuberculosis	5	3	1	9
Renal stone	6	2		8
Renal tumor	2	3		5
Renal ptosis	6	1		7
Renal rotation	1	1		2
Solitary kidney	5	2		7
Aplastic kidney	1	2		3
Ureter stricture	47	31	23	101
Dilated ureter	29	48	62	139
Ureter reduplication:				
Complete	16	9	8	33
Partial	9	13	3	25
Ureter kink	2	2		4
Ureter obstruction by aberrant vessel*	4	6	1	11
Ureter stone		2		2
Pyoureter	1	1		2
Ureter reflux (cystogram)	32	35	52	119
Ectopic orifice in urethra	2	3	1	6
Perinephritic abscess	1	2		3

Report or film lost, 14.

* Seven additional diagnosed; no confirmation.

veilance, it is especially important that children taking sulphanilamide be closely observed lest undesirable, gastro-intestinal, hematologic or dermatologic reactions occur. The dose and bacteriologic indications of mandelic acid and sulphanilamide therapy are noted in Tables II and III respectively.

If the urine cannot be sterilized in ten days by intensive chemotherapy with either mandelic

tions in the young, and (2) the gravity of the "fruits of medical neglect".

SUMMARY

Attention has been directed to the etiological factors in renal infection, and the pathological changes in the kidney have been briefly discussed. Unless these pathologic changes are considered by the clinician, his therapy is likely

TABLE V
TREATMENT EMPLOYED IN 580 CASES OF CHRONIC PYURIA IN CHILDREN

None (refused 9)	30	Cystolithotomy	6
Medical (chiefly antiseptic)	187	Litholapaxy	3
Ketogenic diet	33	Resection of trigone	1
Nephrectomy	46	Diverticulectomy	5
Ureteronephrectomy	15	Electroresection of urethral valves	22
Ureteroheminephrectomy	8	Suprapubic excision of valves	2
Nephrostomy	10	Electroresection of bladder outlet:	
Pyelotomy (stone)	1	For cord bladder	3
Nephropexy	9	For contracture or bar	15
Renal exploration	1	Suprapubic resection of bladder outlet:	
Resection of aberrant vessels	6	For cord bladder	2
Ureteropelvioplasty	4	For contracture or bar	4
Perirenal abscess (incision and drainage)	3	Punch operation:	
Ureteral dilatation	55	For cord bladder	1
Ureteral dilatation with lavage (AgNO ₃)	17	For contracture or bar	3
Indwelling ureter catheter	6	Dilatation of bladder outlet	15
Bilateral transvesical ureteral meatotomy	6	Urethral dilatation	34
Fulguration ureterocele	3	Urethrotomy	2
Ureterostomy:		Resection urethral diverticulum	1
Unilateral	2	Dorsal slit	3
Bilateral	3	Circumcision	2
Bilateral ureteral resection	3	Meatotomy	49
Transplant ureter to bladder	3	High voltage roentgen therapy	3
Indwelling urethral catheter	21	To tuberculosis sanitarium	4
Cystotomy:		Corset for nephroptosis	1
For temporary drainage	25		
For permanent drainage	4		

acid or sulphanilamide, the anatomic diagnosis must be reconfirmed. Often combined anti-septic and urosurgical treatment is necessary. This may be, for example, conservative dilatation of the urethra by sounds or of the ureter by dilating bougie catheters. The surgical treatment will be guided entirely by the demonstrated pathology. Unfortunately, many of these children are not presented for urologic care until advanced renal injury from obstruction or infection requires nephrectomy. The variety of conditions which may produce the clinical picture loosely designated as chronic pyelitis is indicated in Table IV of a personal study of 580 cases by the author. The variety of treatment required in this series is indicated in Table V, a study of which cannot help but impress one with (1) the importance of early diagnosis and treatment of all urinary infec-

to be unsound and fruitless. In the treatment of acute urinary infections in children, combat of dehydration and acidosis and the maintenance of nutrition, far outweigh any considerations of chemotherapy. In persistent urinary infection, a thorough urologic examination must be relied upon for accurate diagnosis. When the urine cannot be sterilized by mandelic acid or sulphanilamide, conservative or radical urosurgical treatment is almost always required—frequently in conjunction with intensive chemotherapy. The pathologic findings and treatment required in a reasonably large illustrative series of cases of persistent pyuria in children indicate not only the frequent failure of chemotherapy alone, but the tragic fruits of medical neglect.

TREATMENT OF UTERINE FIBROIDS, ESPECIALLY THOSE WITH MENORRHAGIA

MATERNAL WELFARE ARTICLE NUMBER THIRTY-SIX

By J. HARRIS UNDERWOOD, M.D., Woodbury, N. J.

Read before the Section on Obstetrics and Gynecology of The Medical Society of New Jersey, on May 18, 1938.

Fibroid tumors of the uterus are not malignant. Some few women with uterine fibroids develop carcinoma of the body or cervix, but this occurs *no more frequently* than in those without fibroids, and is not a cause. Sarcomatous degeneration may take place in a small percentage of them, but this is rare.

HEMORRHAGE

The most common and probably the most disturbing symptom of fibroid uterus is hemorrhage. The chief factor on which the menorrhagia depends is the position of the tumor, and the circulatory disturbance incidental to its growth. The major part of the blood supply to the uterus lies adjacent to the uterine cavity; hence tumors in this area greatly disturb the circulation. Bleeding is often precipitated by nature's effort to expel a submucous tumor.

Before outlining any treatment, it is essential that we diagnose the cause of the abnormal bleeding. The diagnosis of uterine fibroids usually occasions little difficulty. Sometimes, however, when very small subserous tumors exist, diagnosis is well-nigh impossible. A diagnostic dilation and curettage, with examination of the scrapings, is usually indicated, and will either rule out, or diagnose, adenocarcinoma.

DEEP X-RAY THERAPY

With the above points in mind, I have been actuated with the hope that I might outline a conservative treatment which will in many cases save the patient time, expense, and unnecessary hospitalization. In deep x-ray therapy, we have a form of irradiation which we consider a specific in fibroids and most forms of non-malignant bleeding. The technic has undergone various modifications but the following has proven highly satisfactory: 160 *r* units are given to each of four fields (two anterior and

two posterior) to the pelvis. This is repeated three times weekly until a total of 800 to 1200 *r* are given, the amount depending on the size of the tumor and the thickness of the abdominal wall. The factors are 200 K.V., 50 cm.-skin target distance; one-half mm. copper and one mm. aluminum filters. This dose is somewhat in excess of that given in many clinics. The results have been uniformly so satisfactory that we have made no change in this technic for the past five years.

We believe that irradiation is the treatment of choice for:

1. All cases of fibromyoma in women near the menopause in whom the tumor is not larger than a four months' pregnancy, and is not undergoing degeneration.

2. All cases of fibromyoma in women with marked organic heart disease, diabetes, nephritis, and pulmonary tuberculosis.

3. All cases of large fibromyoma in which surgery is contra-indicated because of anemia. Irradiation is contra-indicated in:

1. Cases with large fibromyoma, unless operation is refused.

2. Cases with pedunculated or submucous tumors.

3. Cases with fibromyomata undergoing degeneration.

Some of the advantages of irradiation over surgery or radium are:

1. With x-ray therapy the mortality is nil.

2. There are not the resulting complications such as post-operative radio neurosis, cystitis, pyometra, and prolonged leucorrheal discharge, so often following radium.

3. X-ray can be applied without interference with occupation.

4. X-ray is less expensive; hospitalization is avoided.

5. X-ray has a more homogenous effect on the tumor and ovaries.

6. The effect produced by x-ray is more gradual than that produced by operation, hence there are less marked menopausal symptoms.

7. Nervous shock is largely eliminated.

8. There is no caustic action on the endometrium.

9. There is no resulting stenosed cervix.

Uterine fibroids are a predisposing, though not a positive, cause of sterility. We believe conservative surgery is the treatment of choice in women of the child-bearing age, when the bearing of a child is desired. It is true that fibroids have been treated by irradiation, and have disappeared and normal menstruation established, followed by normal delivery of a normal child; but such results are an exception. There is experimental evidence which indicates that the germ cell may be so modified by irradiation as to establish hereditary abnormalities, if not in the immediate offspring, in descendants one or two generations removed.

The effect of x-ray on vessels is the production of an edema of the endothelium of the capillaries, which creates an obliterating endarteritis, thereby cutting down on the blood supply. The fibroid tumor cell is gradually oblit-

erated and replaced by young connective tissue. This does not impair the sexual function. It does not predispose to cancer. There is no danger of x-ray burns in experienced hands; and there is no tendency to become obese. Women under forty years of age should not be subjected to radiation unless appraised of the fact that effective treatment will probably stop ovarian function.

In cases of young women with the desire for future pregnancy, myomectomy is the appropriate treatment; if this operation is refused, or myomectomy is impossible, treatment by irradiation is indicated, care being taken for the protection of the ovaries.

CONCLUSION

Since surgical operations are attended with some mortality, pain, and considerable expense; since radium has a long list of contraindications; and since deep x-ray treatment in selected cases of uterine fibrosis is effectual, convenient and less expensive, and the contraindications much fewer, we urge a careful study of cases, and recommend that more have x-ray treatment.

A LESSON FROM DEATH CERTIFICATES

NUMBER EIGHT

The maternal mortality rate for New Jersey was higher for 1938 than for 1937,—35 per ten thousand live births. Why?

Number of deaths from puerperal sepsis increased 16 per cent. Why?

Number of deaths from puerperal hemorrhage increased 40 per cent. Why?

Number of deaths from ectopic gestation increased 62 per cent. Why?

In 35 per cent of the maternal deaths there was no pre-natal care. Why?

Ten counties made a better showing in 1938 than in 1937.

Nine counties made a poorer showing in 1938 than in 1937. Why?

Two counties had the same rate as in 1937.

A. W. BINGHAM, M.D., *Chairman,*
Maternal Welfare Committee.

THE PRESIDENT'S PAGE

NUMBER ELEVEN

THE NATIONAL HEALTH ACT OF 1939

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

On February 28, 1939, Senator Wagner of New York introduced into the Senate of the United States S-1620, known as the *National Health Act of 1939*.

The heterogeneous purposes of the Bill are "to provide for the general welfare by enabling the several States to make more adequate provisions for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospital and health centers, care of the sick, disability insurance and training of personnel, to amend the Social Security Act, and for other purposes.

The Bill has much to commend it. The humanitarianism of its distinguished author is well known. While the Bill is the outgrowth of the National Health Conference, it omits reference to compulsory health insurance to which the medical profession so strenuously objects. For the omission we are grateful. It wisely grants States the privilege of setting up their own health programs. While these programs must be approved by Federal Bureaus, there is as yet no apparent disposition on the part of these bureaus to impose unreasonable restrictions. The National Health Conference recommended the expenditure of \$850,000,000 the first year to be increased until the enormous sum of \$2,600,000,000 a year was to be appropriated. The Wagner Act provides for the expenditure of \$85,000,000 for the first year. For this we and other taxpayers are grateful.

The Wagner Bill is divided into five parts.

1. MATERNAL AND CHILD HEALTH

Part one provides for maternal and child health service, \$8,000,000 of Federal funds for the first year which ends June 30, 1940; \$20,-

000,000 for the second year; \$35,000,000 for the third year; and q. s. ad lib for each year thereafter. Allotments to States are to be made by the Chief of the Children's Bureau with the approval of the Secretary of Labor according to the number of births, the need, the financial resources, and the special problems involved. In order to receive Federal funds the States themselves must raise a sum equal to from one-third to two-thirds of the Federal grant.

If any State cannot or will not sweeten the pot by matching funds, it loses its original ante, because Federal funds are actually State funds from another pocket. In this game of stud poker, the Wagner Health Act makes it mandatory for all States to sit in and chip in. They cannot decline to play until they have anted up their share of the 8, 20, 35, or q. s. millions that make up the Federal grants. Moreover, the States must have a plan of distribution which meets the approval of the Chief of the Children's Bureau and of a Federal Advisory Committee the make-up, duties, and responsibility of which are exceedingly vague. For the administration of part one, \$3,000,000 are appropriated the first year; \$3,500,000 the second year; \$4,000,000 the third year; and q. s. ad lib thereafter.

2. PUBLIC HEALTH WORK

Part two enables the States, especially rural and financially embarrassed States (those that are not financially embarrassed are not named), to extend and improve public health work including services, supplies, and facilities for the control of tuberculosis, malaria, pneumonia, cancer, mental health, and industrial hygiene.

Let us note parenthetically that venereal disease control is not included. Funds for this phase of the public health service, however,

will be available if the Bullwinkle-LaFollette Bill becomes a law.

This is another illustration of the confusion and obfuscation which has characterized the health administration of the Federal Government of the past forty years. As far back as 1935, President Roosevelt realized the need to coördinate and correlate the health activities scattered among numerous departments of the Federal Government. He appointed an Interdepartmental Committee with the specific duty (Executive Order No. 7481) to effect this co-ordination. The Interdepartmental Committee and its Technical Advisory Committee forgot or ignored Executive instructions, compounded confusion by making fragmentary surveys which seemed to show that one-third of the people were not receiving adequate medical care; and concluded, therefore, that the Government ought to take over the practice of medicine. While it is true that the distribution of medical services in America is by no means perfect, it is equally true that the present morbidity and mortality rate is the lowest in recorded history. It is equally true that our people receive better medical care than any other people on earth. Moreover, the medical center of the world has shifted from Europe to the United States, because political control has blighted medical advance in Europe.

For forty years the doctors of America have urged the Government to coördinate its health work under a Federal Health Department with a physician cabinet officer at its head. Instead of this, the Wagner Health Act gives divided authority to a hydraheaded administrative monstrosity with authority scattered promiscuously to the Chief of the Children's Bureau, the Surgeon General, the Secretary of Labor, several Federal advisory councils, the F. E. A., and the Social Security Board. The control of venereal disease, the pet project of the Surgeon General, is not even mentioned in the Act.

For public health work and investigation, \$15,000,000 is appropriated the first year, \$25,000,000 the second, \$60,000,000 the third, and an unnamed but sufficient sum for each year thereafter. The allotment is to be made by the Surgeon General according to rules prescribed by him and approved by the Secretary of the Treasury according to needs and resources. Provision is made for the President to revamp the public health service. The States must raise a sum of money varying from one-third to two-thirds of the Federal appropriation.

3. HOSPITALS

Part three proposes to assist States, especially rural and financially embarrassed States,

to construct and improve additional hospital facilities, and to operate them for three years. Three million dollars is to be appropriated the first year; \$50,000,000 the second; \$100,000,000 the third year; and q. s. ad lib each year thereafter. Allotments are to be made by the Surgeon General of the Public Health Service according to needs and resources. In order to receive Federal funds a State must contribute a sum amounting to from one-third to two-thirds of the Federal grant. Labor must be paid wages fixed by the Commissioner of Labor; and the title, location, plans, specification, and supervision, and the performance of the contracts must be approved by the F. E. A. or its alphabetical successor. Ownership of real estate and equipment is vested in the State. Maintenance of these hospitals is provided for on a descending scale. Three hundred dollars per year is available for each bed in general and tuberculous hospitals the first year; \$200 the second; and \$100 the third. Beds in mental hospitals are granted one-half of these sums.

It should be noted that this is the only exception in the entire bill to the rule that expenditures rise each year. All other costs leap nimbly from arithmetical to astronomical sums. For the administration of part three, \$1,000,000 is provided the first year; and q. s. for each year thereafter, which does not include an unnamed sum for the F. E. A.

4. MEDICAL CARE

Part four authorizes grants to States, especially rural and financially embarrassed States, for extension and improvement of medical care which includes services, supplies, and treatment, and for the training of personnel. The Act does not state whether the personnel means doctors, nurses, orderlies, or public accountants. For this purpose \$35,000,000 is appropriated for the first year; and for each year thereafter an unnamed but sufficient sum, plus \$1,000,000 for administration. In allocating Federal funds to States, their proportionate share shall not include State expenditures in excess of \$20 annually per individual eligible for medical care, nor the sums expended for the care of mental and tuberculous hospitals. State plans must be approved by Federal agencies, Social Security Board, and a Federal Advisory Committee. In order to secure Federal funds, the States must match them at varying proportions. Thus for every \$100 of Federal funds a State must appropriate a sum ranging from \$200 to \$833.

5. TEMPORARY DISABILITIES

Part five provides grants to States for temporary disability compensation amounting to \$10,000,000 for the first year, and an unnamed sum for each year thereafter providing each State develops a plan approved by the Social Security Board, and a Federal Advisory Board, provided further that opportunity for hearing is afforded before impartial tribunals for those whose claims are denied. If adequate medical services are not made available, or if a substantial number of disabled are denied compensation, the Social Security Board may withdraw Federal funds. The States are not required to match Federal funds for temporary disability compensation.

DEFINITIONS

Appended to the Bill are some definitions:

1. Temporary disability compensation means cash benefits for not more than fifty-two weeks, and not arising out of or in the course of employment.
2. Disability means the inability to work or unfitness for work due to injury or illness.
3. Employment means any service except agricultural labor, domestic service, or casual labor.
4. Employee includes all traveling salesmen. The Wagner Health Act provides neither for the farmer's daughter nor the traveling salesman.

APPROVED PROJECTS

The Bill authorizes vast unnamed ad lib sums of money for purposes the need of which has not been shown. It loosens the frayed strings of the "bottomless" Federal purse, and it confers tremendous power on Federal bureaus. We are not stubborn obstructionists, however, and recognize much in the Bill that is wholesome. The present Congress is composed of real statesmen, independent thinking humanitarians. We earnestly hope that they will:

1. Amend the Wagner Health Act.

2. Establish a Federal Department of Health.

3. Grant reasonable sums named in the Bill for needed expansion of public health activities, maternal and child health services, and additional hospital beds *for the first year only*.

We also hope that future expenditures will be based on the needs as they then exist, on the financial resources of the nation, and on the success or failure of the expanded health program. We implore the Congress to study the need and cost of disability insurance, before appropriating unlimited millions of dollars.

THE INDIGENT

Finally, the medical profession believes that the adequate care of the medically indigent is the only real medical emergency that requires hasty legislation. We are willing to enter into any plan that is economical and non-political to supply medical services to the medically indigent. We believe that the care of the medically indigent is the dual responsibility of the Government and the medical profession; and we are willing, as our contribution, to furnish professional services at cost. From our experience with the E. R. A. in New Jersey, we believe the best plan is to permit the indigent to employ practitioners of their own choice who are reimbursed by the State. From the best data that we have been able to gather and from our own experiences, we believe that adequate service to the indigent can be given at a cost of from \$6 to \$8 per person, per year, on the insurance principle. We believe that the determination of who is, and who is not, indigent is exceedingly important. On the one hand, no American should be deprived of adequate medical care. On the other hand, the indiscriminate branding of individuals as indigents because their income is below some arbitrarily fixed level destroys self-respect and self-reliance,—qualities that made America great. We believe that the determination of indigency and plans for relief administration are local problems.

OBJECTIVES OF THE COMMITTEE ON THE ANNUAL MEETING

By CHARLES B. KAIGHN, M.D., Atlantic City, Chairman

The 173rd Annual Meeting of The Medical Society of New Jersey, which will be held in Haddon Hall, Atlantic City, on June 6-8, 1939, will be the culminating event of a year of unprecedented activity and progress. It will also be an opportunity to formulate plans for a still wider adaptation of all phases of medical service to the needs of the people.

The return of the annual meeting to Haddon Hall assures the members of adequate, well-planned rooms and ample facilities for carrying out every item of the program.

SCOPE OF ACTIVITIES

The committee is charged with the general direction and supervision of all phases of the management of the annual meeting. It is especially concerned with the coördination of the hours and rooms for the several meetings and events, and the facilities for carrying out every item of the program. It is the liaison agent in the relations of the officers and committees with the managers of the hotel in which the annual meeting is held.

SCIENTIFIC PROGRAMS

General Session.—A program for a general session on administrative medicine is now being prepared by a sub-committee of which Dr. Clarence L. Andrews, Atlantic City, is chairman. This committee is in correspondence with outstanding leaders in the newer relations of the medical profession to the community, and will soon be able to announce the names of those who accept the invitation to be our guest speakers.

Scientific Sections.—The newer methods of the diagnosis and treatment of diseases will be exemplified in the meetings of the seven scientific sections, whose subjects will be announced in the official program.

Scientific Exhibits, under the experienced direction of Dr. Asher Yaguda, Newark, will be more interesting and informative than ever before.

Social.—The social side of the meeting will be under the auspices of the Woman's Auxiliary, culminating in the annual banquet.

History and Art Exhibits will be assembled by the *Woman's Auxiliary*, and the exhibition room will be easy of access and of ample size. The exhibit will be of special interest as a

demonstration of progress in carrying on the State Society project of discovering the original sources of information regarding the origin and development of the present organization.

CO-ORDINATION

The committee also has the responsibility of coördinating all the varied preparations for the annual meeting. Its work begins weeks before the annual meeting. It receives the programs of the several officers and committees, and provides them with the rooms and other facilities for carrying on their activities.

The committee will announce the final plans in the *official program* which will be printed in *The Journal of May*.

In all its varied activities the committee has the assistance of the Executive Officer, Dr. LeRoy A. Wilkes, who, by action of the House of Delegates and the Trustees, is the representative and adjutant of President Carrington.

The several groups for whose accommodations the Committee on Arrangements is responsible are as follows:

1. The House of Delegates and its Reference Committees.
2. The several boards and committees of the Society.
3. The scientific sections.
4. The Woman's Auxiliary and its exhibit of art and medical history.
5. The Annual Banquet.
6. The Technical Exhibits.
7. Reunions and social gatherings of groups of members.

OBJECTIVE

The objective of the committee is to make provision for all phases and events of the annual meeting, and to announce them in the printed program. But in order to provide for unforeseen conditions, a member of the committee and the Executive Officer will be on duty at all hours during the sessions.

Members attending the annual meeting will find satisfaction in the program, both scientific and social. Of equal importance will be the opportunity to observe the Society in action, and to enlarge their acquaintance with their fellow workers.

STATE SOCIETY ACTIVITIES

PRE-NATAL CARE FOR INDIGENTS

The following circular of information has been sent to all physicians in the rural districts of New Jersey:

The Committee on Maternal Welfare of The Medical Society of New Jersey wishes to help your County Society to organize a Community Pre-natal System in your county. (See report of the Conference on Maternal Welfare, Jour., Feb., 1939, p. 116; and report of the Welfare Committee, Jour., March, 1939, p. 168.)

This system is designed only for the indigent and low-wage group in those districts in the county not provided with Pre-natal Centers. The set-up and functions of this system will be supervised by an executive committee, consisting of the field physician as chairman, two members of the County Medical Society appointed by the President, and a representative of the nursing organizations.

The field nurse will contact the patient, and

then telephone the field physician, who will see that the patient is assigned to a physician in the neighborhood, who will give her pre-natal care free of charge.

Each physician will be required to treat only a few patients in his office. He assumes no responsibility for the delivery, unless he wishes to do so. Most of the patients will be delivered in some hospital.

The physician will keep a pre-natal record, using the card provided by the State Department of Health, which is given to the patient when she is ready to go to the hospital.

If you are willing to assist in establishing this service in your county in the interests of better obstetrics, please sign and return the enclosed postal card.

ARTHUR W. BINGHAM, *Chairman,*
Committee on Maternal Welfare.

BROADCASTING YOUR CHILD'S HEALTH

JOINT PROGRAM OF THE MEDICAL SOCIETY OF NEW JERSEY, AND RUTGERS UNIVERSITY

Representatives of The Medical Society of New Jersey will be heard over Station WOR every Thursday afternoon, at 1:45 to 2 p. m., from April 6 to June 29,—a period of thirteen weeks.

The Medical Society of New Jersey and the New Jersey State Dental Society have been invited by the Home Economics Extension Service of Rutgers University to sponsor this series jointly as a part of the continuing program of its Homemakers' Forum.

The theme of the program is "Your Child's Health". The program will cover general principles of care of the child, from birth through adolescence.

Participation of medical speakers has been arranged by the State Society's Committee on Public Relations. The program is an expression of two committee objectives: 1, To educate the public in health matters; and 2, to secure recognition of The Medical Society of New Jersey as a source of reputable health information.

A copy of the program has been sent to every member of The Medical Society of New Jersey by the Rutgers University Extension Service. Additional copies may be obtained from the Public Relations Committee, 77 Livingston Avenue, New Brunswick.

Physicians are urged to display copies of the program in their waiting rooms, and to call the attention of their patients to the program.

The complete program is as follows:

April 6—*The First Baby and His Parents*

Joseph H. Kler, M.D., Chairman Committee on Public Relations, 'Medical Society of New Jersey.

Philip L. Schwartz, D.D.S., Vice-President New Jersey State Board of Dental Examiners.

Marion F. McDowell, Extension Specialist in Child Training and Parent Education.

April 13—*Those First Six Months*

Chester R. Brown, M.D., Fellow American Academy of Pediatrics.

Marie Doermann, Extension Specialist in Nutrition.

April 20—One Candle on His Cake

Kenneth Blanchard, M.D., Fellow American Academy of Pediatrics.

James L. Hughes, D.D.S., Council on Mouth Hygiene, New Jersey State Dental Society.

April 27—The Sturdy Young Toddler

Frederick Lathrop, M.D., Public Health Committee, Medical Society of New Jersey.

Evelyn T. Walker, R.N., Monmouth County Organization for Social Service.

May 4—Off to Nursery School

Joseph H. Kler, M.D.

Eugene Newman, D.D.S., Council on Mouth Hygiene, New Jersey State Dental Society.

May 11—Making Friends with the Family Physician

LeRoy A. Wilkes, M.D., Executive Officer, Medical Society of New Jersey.

May 18—Making Friends with the Family Dentist

J. M. Wisan, D.D.S., Chairman Council on Mouth Hygiene, New Jersey State Dental Society.

May 25—School Days

Allen G. Ireland, M.D., Division of Health, Safety and Physical Education, New Jersey State Department of Public Instruction.

Horace Tatum, D.D.S., Council on Mouth Hygiene, New Jersey State Dental Society.

June 1—Appearance, Health and Personality

Henry A. Davidson, M.D., Fellow American Medical Association.

Phillip L. Schwartz, D.D.S.

June 8—Play Hours

Harry Silver, M.D., Assistant Director, Bureau of Child Hygiene, Newark, N. J.

Harriet Stone, Supervisor of Nutrition, Board of Education, Newark, N. J.

June 15—Growing Up

Maurice Ripps, M.D., Fellow American Academy of Pediatrics.

Craft A. Hopper, D.D.S., President New Jersey State Dental Society.

June 22—Still Growing Up

Harold Murray, M.D., Fellow American Academy of Pediatrics.

J. M. Wisan, D.D.S.

June 29—Choosing Your Physician and Your Dentist

William J. Carrington, M.D., President Medical Society of New Jersey.

K. C. Pruden, D.D.S., F.A.C.D., President New Jersey State Board of Dental Examiners.

LEGISLATIVE BULLETIN NUMBER THREE

PLEASE SAVE ALL LEGISLATIVE BULLETINS FOR FUTURE REFERENCE

Telephone the Executive Offices (Trenton 9330—reverse charges) in case of any unusual developments; and in all instances write us after you have had an interview with your local Legislator(s) on proposals in which the profession is directly interested.

LEGISLATIVE BATTLES ARE WON OR LOST BACK HOME

Keep your Senator and Assemblymen informed as to the attitude of the Medical Profession in New Jersey

THE UNIFORM MEDICAL PRACTICE ACT

A-210—McClave—Feb. 20—The Uniform Medical Practice Act, A-210, has been transferred from the Judiciary Committee to the *Public Health Committee in the Assembly*. The members of the Public Health Committee are as follows:

Dr. Frank S. Hargrave, 83 Kenilworth Place, Orange

Dr. S. Emlen Stokes, 129 Chester Avenue, Moorestown

Dr. Adolph Wegrocki, 186 Warwick Street, Newark

Mr. Robert K. Worrell, Blackwood

Dr. Charles Browne, Cleveland Lane, Princeton

It is very urgent that the legislators in the county be contacted promptly by a delegation from the County Medical Society consisting of the President, Secretary, and "Keyman", and also the family doctor of the legislator and any additional members of the County Society you choose to go with them.

There are just four essential points in A-210 which are to be stressed. Legal terminology in-

volves the use of a lot of words, but there is nothing in this bill that is not in the public interest. The claim of the chiropractors that they are a martyred group and are discriminated against is the exact opposite of the truth. They are admitted to practice, within the limitations of the system which they claim to be all-sufficient, with far less investment of time, money, and effort than any other group that practices in general the healing arts. Investigations by the most responsible groups in this country have failed to substantiate their claims or to justify their ideology and philosophy. If they will meet the same standards of preparation as the legal practitioners of medicine and surgery, including those who practice osteopathy, the chiropractors shall then be free to practice their own technics so long as the public may demand them.

The other parts of A-210 are non-controversial. We want to stop the violators of the practice act by imposing larger fines, or by jail sentences if all other means fail. We want to remove the license

from those who suffer from insanity, and those who willfully work against the public interest as defined in the bill. We want to restrict personal claims of those practitioners who would merely admit they were exceptionally good without having to prove it. (In the latter case it would not be necessary for them to admit their excellence.) Surely no legislator can honestly disagree with the aims of this bill as it is now presented.

If you will explain these points carefully to your legislators, and convince them of the unity and sincerity with which this bill is supported by the

medical profession in the interests of public health, we are optimistic as to its becoming a law.

The chiropractors are extremely active in the legislature. They are themselves divided into two groups, each of whom is reported to be ready to introduce a bill. These bills are often cleverly drawn to conceal their *real* purpose. A close watch is being kept on medical legislative bills in Trenton, but the real conviction comes to the legislator in his own county as a result of the interest and activity manifested and sustained by the representatives of the medical profession whom he knows.

SENATE BILLS

S-15—Foran (for Hendrickson)—Jan. 16—This bill has been modified with a committee amendment. It is still bad in that it opens up the sale of drugs to be sold in stores other than pharmacies. This opening wedge, if gained now, can be easily amended to remove restrictions; and all sorts of poisons and drugs may be removed from the competent hands of trained pharmacists and put into stores run by people trained for purposes other than health service. This bill should be defeated. Jan. 16—Miscellaneous Business Committee.

S-51—Foran (for Hendrickson)—Jan. 23—This is a good bill and should be approved in the interest

of maintaining morale among the hospital staff and thus aiding in controlling the already overburdened hospital economic problem. Both of these aims are essential to good service to the sick. Jan. 23—Labor, Industries, and Social Welfare Committee.

Both of the foregoing bills are *out of committee*, and have had the first reading.

S-171—Stanger—Feb. 27—This bill requires not only physicians, but pharmacists and hospital heads, to report venereal disease patients to the State Department of Health. It also makes it a misdemeanor for a person infected with venereal disease to neglect treatment. *Approved*. Feb. 27—Public Health Committee.

ASSEMBLY BILLS

A-48—Mahr—Jan. 23—This bill has a very good *purpose*, but from first-hand observation one can see that eye and ear tests for "screening" purposes are now being given in most public and private schools throughout the country. Those in need of treatment are referred to family physicians and proper specialists. Conditions in the schools do not permit of proper examination by a specialist. The school was founded for *education*; the hospital and doctor's office are for *medical service*, and are designed, constructed, and equipped for this service far better than an educational rendering institution. Jan. 23—Public Health Committee.

A-62—Wegrocki—Jan. 23—This bill proposes a special license for one *particular individual* who cannot meet the required standards. When such a loophole is opened up for a particular person, others who cannot meet the standards which we are trying to maintain also slip through. Last year we had a similar bill, and *five additional practitioners* slipped in along with the special beneficiary for whom the bill was intended. These bills are increasing in frequency as one succeeds, and there is one now just introduced which appears to be similar in purpose, judging by its title. You will be informed on this point after the bill has been carefully read. In any case watch A-318, introduced by Assemblyman Palese on February 27th which is now in the Public Health Committee. *Opposed*. Jan. 23—Public Health Committee.

A-199—Wegrocki—Feb. 13—This chiroprody bill is really an endeavor by the chiropodists to *make further inroads into the practice of orthopedic surgery*, without adequate preparation. Even if the course in chiropody were extended to four years,

the necessary background and training for this work could not be given outside of a regular medical course. Chiropody should be limited to minor foot ailments for which these technics were originally established. The definition of chiropody given is as unsatisfactory as ever. The language in this bill is so bad as to open up the possibilities of abuse under the definition,—"Chiropody shall be defined as that branch of medicine and surgery which treats 'with' ailments of the foot and leg, and includes the diagnosis of the medical, surgical, mechanical, manipulative, and electrical treatments of all the ailments of the human foot and leg." As worded, the *diagnosis* of the *treatment*, rather than of the *etiological* factor is indicated. Again the diagnosis is made upon *symptoms*. Apparently physical findings play no part in chiropody, contrary to their obvious practice. There is no restriction under the term "medical treatment" in the bill, and while it may not be so intended, the wording would seem to permit the giving of medicine internally. Manipulative treatment is not defined. Electrical treatment includes "rays and the like". Does not this wording give them the right to use *radium*? *To be opposed*. Feb. 13—Public Health Committee.

A-286—Glickenhau—Feb. 27—This bill creates a bureau of narcotic control. *Not approved*, because we already have an efficient federal control bureau, and the State Department of Health disclaims any responsibility for this bill. Feb. 27—Public Health Committee.

N.B.—It is interesting to note that in A-267, A-316, and S-167 *citizenship* is required of dentists, doctors, pharmacists who wish to take the examination for license in these professions.

TRIBUTE TO DR. EPHRAIM ROLAND MULFORD

Dr. Ephraim R. Mulford, who served as the 149th President of The Medical Society of New Jersey during the year beginning June 8, 1928, died suddenly at Farmington Country Club, Charlottesville, Virginia, on March 10, 1939.

Dr. Mulford was born in Cedarville, Cumberland County, New Jersey, October 17, 1880, the son of Ephraim Mulford and Sara Westcott. His early childhood was spent in the healthful environment of the river and lake region of South Jersey. Later his parents moved to Bridgeton in order to educate their children. Bridgeton was then shut off from the detrimental phases of city life, so that the children enjoyed an abundance of skating, sleighing, and ice hockey in Winter, and swimming, rowing, and paddling in Summer. But there was work to be done on his father's boats and farms, and hard work and outdoor play built up a fine physical and spiritual reserve for the young man. Throughout his life his work and his love of the outdoors were his greatest pleasures.

He was graduated in 1899 from the South Jersey Institute at Bridgeton, at that time the best preparatory school in that district. He then entered the University of Pennsylvania, but through the influence of the family physician, Dr. John Moore, he withdrew and placed himself under the sphere of Thomas Jefferson's inspiration, the University of Virginia, from which he was graduated in 1903.

On the 18th of March of that year he married Martha James Anderson, daughter of Richard D. Anderson and Maria Caroline White. Mr. Anderson was the "Father of Athletics" at the University of Virginia.

Dr. Mulford spent his interne year in the Bellevue Hospital in New York, and did post-graduate work in the Good Samaritan Hospital there. He then returned to Virginia where he practiced until 1908, spending one year in post-graduate work at the University of Virginia. He and his wife and their four children moved to New Jersey in 1909. In Burlington a large practice was slowly built, and here four other children were born. Dr. Mulford is survived by his wife and the following children: E. Roland Mulford, Jr., of Burlington; Mrs. Caroline Walsh, of New Haven, Connecticut, wife of Dr. Joseph Walsh; Mrs. Martha Wyman, wife of Dr. Edward Wyman, of Burlington; Mrs. Louise Hiden, wife of Dr. Conway Hiden, of Princeton; William Pinkerton Mulford, a third-year medical student at the University of Virginia; Maurice Mulford, a



DR. EPHRAIM R. MULFORD

student at the University of Pennsylvania; and David Mulford, of Burlington.

From the start, Dr. Mulford became interested in organized medicine and in 1921 he served as President of the Burlington County Medical Society. He spent long hours in organizing and building the Burlington County Hospital at Mt. Holly. Due largely to his influence, that hospital has maintained high professional standards from the beginning.

His year as President of The Medical Society of New Jersey was constructive. Since that time Dr. Mulford has served continuously as one of New Jersey's members of the House of Delegates of the American Medical Association.

Because of his personal charm and sound judgment, he was loved, honored, and respected by his patients, and by his confreres in Burlington County, in New Jersey, and throughout the nation. No printed words of ours can change "Mul's" record on the scroll of the recording angel, nor would we change it if we could. What has been written he wrote himself. Countless good deeds are there recorded. Memories of them are etched on the minds of his patients and engraved on the hearts of his colleagues.

For ten years Dr. Mulford suffered from attacks of angina pectoris. The final attack

came in Charlottesville, Virginia, where he and his wife had gone to attend the wedding of his best friend's daughter. He did not linger "until the flame lacked oil", but passed from us while he yet loved life, with all his senses keen and all the faculties of his mind alert. There is this consolation: never again will he suffer from the clutching agony of angina, or from the pangs of parting.

Many qualities made him great and good, but five stand out like the five points of a guiding star.

1. He was tolerant. His circle of friends encompassed men of many creeds.

2. He loved his family. He left them the richest legacy a man can leave,—inspiring memories.

3. He loved people and people loved him. For three hours during his funeral, no wheel of industry turned in the city of Burlington.

4. He loved Nature. He stood enraptured before the beauties of field, and stream, and sun, and sky, and stars.

5. He loved his profession, because it gave him opportunity to serve mankind.

His strong, kind face is etched on our memories like a family portrait. His spoken words were music, and we shall carry into the far evening of our lives inspiring memories of his face and voice.

"Let me go quickly, like a candle light
Snuffed out just at the hey-day of its glow.
Give me high noon—and let it then be night.

And grant that when I face the grisly Thing
My song may trumpet down the Gray

Perhaps.

Let me be as a tune-swept fiddle string
That feels the Master Melody—and snaps."

DR. ELWOOD E. DOWNS

Dr. Elwood E. Downs, of Woodbury, Gloucester County, died suddenly on March 18, 1939, from an embolus following an appendix operation from which he had apparently recovered.

Dr. Downs was born in Franklinville, Gloucester County, on March 26, 1890. He graduated from the Hahnemann Medical College, Philadelphia, in 1913, and has practiced medicine in Woodbury and vicinity ever since. He was Radiologist to the Underwood Hospital, Woodbury; the Salem County Memorial Hospital; and the Jeanes Hospital, Fox Chase, Pa. He was a Past President of the Philadelphia Roentgen-Ray Society; a member of the American Radiological Association; and a Fellow

of the American College of Radiology. He was twice President of the Gloucester County Medical Society.

Dr. Downs was public-spirited. He was President of the Woodbury Board of Education, a Past President of the Woodbury Kiwanis Club, and a member of Masonic Lodge of Svedesboro. He leaves a wife, and three children—Jane, a student nurse in the University of Pennsylvania Hospital; Hunter, a pre-medical student in Colgate University; and Richard, aged ten years.

Dr. Downs was genial, and was popular in the community, and conscientious in his contacts with his fellow practitioners.

DR. W. W. GOSLING

Dr. Walter W. Gosling, of Red Bank, New Jersey, died from a cerebral hemorrhage on March 4, 1939, at the Fitkin Memorial Hospital, Neptune, N. J., while he was convalescing from a fractured vertebra.

Dr. Gosling was born in Brooklyn, New York, on June 23, 1897. He took his pre-medical course at Cornell University, and received his medical degree from Hahnemann Medical College, Philadelphia, in 1923. His surgical studies were completed at the University of Pennsylvania.

He was Chief of Staff at the Riverview Hospital, Red Bank, for two years, and was on the surgical staff at the Fitkin Memorial Hospital. He was a Past President of the Red Bank Rotary Club, and a member of the Mystic Brotherhood Lodge, F. and A. M., Hiram Chapter, Royal Arch Masons, and Consistory of Salaam Temple, Shriners.

Dr. Gosling is survived by his wife, Mrs. Hazel Codington Gosling; three children, Richard, Barbara, and Phyllis, and his mother, Mrs. Flora Wilcos Gosling.

DR. HURLBURT H. TOMLIN

Dr. Hurlburt H. Tomlin, of Wildwood, Cape May County, aged sixty-two years, died suddenly on March 10, 1939, while on a South American cruise.

Dr. Tomlin was born at Hammonton, N. J., the son of the late Captain Francis Henry and Antoinette Tomlin. He was a graduate of the University

of Pennsylvania, and had practiced in Wildwood for the past thirty years.

Dr. Tomlin has been a member of the Cape May County Medical Society since October 2, 1906, and was serving as its President and Treasurer at the time of his death. He had long been active in civic

affairs, being a charter member of the Wildwood Kiwanis Club, and the Wildwood Golf Club, and was a director of the Wildwood Trust Company. During the World War he served as a First Lieutenant in the Medical Corps of the U. S. Army.

Dr. Tomlin was held in high esteem by his fellow

practitioners and was respected by all in his community. His death is a great loss to the general public for whom he toiled long and well.

W. D. ROBBINS, *Secretary*,
Cape May County Medical Society.

DECEASED PHYSICIANS—NEW JERSEY IN FEBRUARY, 1939

Data Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Jules Baechler	61	Feb. 11	Weehawken	West New York	Cerebral apoplexy.
George H. Baker	85	Feb. 8	Marlboro Hosp.	Freehold	Bronchial pneumonia.
Martin Cole	89	Feb. 25	Newton	Hainesville	Chronic myocarditis and broken hip.
Anna M. S. Graves	86	Feb. 20	Newark	Same	Fracture of femur.
Joseph P. Riggs	59	Feb. 24	Franklin	Jefferson Twp.	Lobar pneumonia.
Herbert Strandberg	48	Feb. 24	Carteret	Same	Chronic congestive heart failure.

NUMBER OF CHILDREN REPORTED RECEIVING FREE STATE BIOLOGICALS
SINCE JULY 1, 1938

DIPHTHERIA TOXOID

County	Total to Jan. 31	Month of Feb.	Total to Feb. 28	Average per Month
Atlantic	612	113	725	20.6
Bergen	2185	94	2279	284.8
Burlington	251	128	379	47.3
Camden	1156	25	1181	147.6
Cape May	354	2	356	44.5
Cumberland	83	8	91	11.3
Essex	7398	783	8181	1025.1
Gloucester	70	49	119	14.8
Hudson	3028	6	3034	379.2
Hunterdon	5	0	5	.6
Mercer	1423	851	2274	284.2
Middlesex	942	42	984	120.5
Monmouth	278	27	305	38.1
Morris	308	15	323	40.3
Ocean	120	82	202	25.2
Passaic	1928	97	2025	253.1
Salem	192	41	233	29.1
Somerset	95	9	104	13.
Sussex	5	0	5	.6
Union	1046	80	1126	140.7
Warren	348	18	366	45.7
Totals	21827	2470	24297	3037.1

SMALLPOX VACCINE

County	Total to Jan. 31	Month of Feb.	Total to Feb. 28	Average per Month
Atlantic	493	21	514	61.6
Bergen	1679	41	1720	215.
Burlington	248	3	251	31.3
Camden	2183	8	2191	273.8
Cape May	336	10	346	43.2
Cumberland	204	4	208	26.
Essex	3497	281	3778	472.2
Gloucester	406	3	409	51.1
Hudson	2661	139	2800	350.
Hunterdon	17	0	17	2.1
Mercer	952	5	957	119.6
Middlesex	1683	41	1724	215.5
Monmouth	1006	41	1047	130.8
Morris	661	23	684	85.5
Ocean	45	5	50	6.2
Passaic	1410	85	1495	186.8
Salem	357	28	385	48.1
Somerset	1145	4	1149	143.6
Sussex	0	0	0	0.
Union	906	41	947	118.3
Warren	152	1	153	19.1
Totals	20041	784	20825	2063.1

BOOKS RECEIVED FOR REVIEW

Medicine in Modern Society. By David Riesman, M.D. Cloth. Price, \$2.50. Pp. 226. Princeton, New Jersey: Princeton University Press; London; Oxford University Press. 1938.

Medico-legal Text on Traumatic Injuries. By Lou's J. Gelber, M.D., LL.B., F.A.C.M.-L. Cloth. Price, \$6.00. Pp. 482. Newark, New Jersey: Soney & Sage. 1938.

Industrial Hygiene. By L. B. Chenoweth, M.D., and W. F. Machle, M.D. Cloth. Price, \$2. F. S. Crofts & Co. New York. 1938. Pp. 235. Illus.

Clinical Gastroenterology. By Horace Wendell Soper, M.D., F.A.C.P. Cloth. Pp. 314 with 212 illustrations. St. Louis, Missouri. The C. V. Mosby Company. 1939.

Vaginal Diaphragm; Its Fitting and Use in Contraceptive Technique. By Le Mon Clark, M.S., M.D. Cloth. Pp. 107, illustrated. St. Louis, Missouri, The C. V. Mosby Company. 1939.

Spinal Anesthesia. By Louis H. Maxson. Cloth. Pp. 409. Philadelphia, London, New York and Montreal: J. B. Lippincott Co. 1938. Price, \$6.50.

Interns' Handbook: A Guide, especially in emergencies, for the intern and the physician in general practice. By M. S. Dooley, 2d ed. rev. & reset. Cloth. Pp. 523. Price, \$3. Philadelphia, London, Montreal: J. B. Lippincott. 1938.

Medical Writing: The Technic and the Art. By Morris Fishbein and Jewel F. Whelan. Cloth. \$1.50. Pp. 212, with 34 illustrations. Chicago, Illinois, American Medical Association.

Trauma and Internal Disease: a Basis for Medical and Legal Evaluation of the Etiology, Pathology, Clinical Processes Following Injury. By Frank W. Spicer, A.B., M.D., F.A.C.P. Cloth. Price, \$7.00. Pp. 593, with 43 illustrations. Philadelphia, Montreal and London: J. B. Lippincott Company. 1939.

INDUSTRIAL HYGIENE. By Laurence B. Chenoweth, A.B., M.D., and Willard Machle, B.S., M.D. 235 pages. F. S. Crofts & Co.

This book is intended primarily for use as a handbook of hygiene and toxicology for engineering students, and as a ready reference for engineers and plant managers.

Most of the fifteen chapters present their subjects in a condensed form, yet covering the important points. Following an historical introduction, the authors speak of Workmen's Compensation in more or less general terms. The presentation of Heinrich's classification of industrial accidents should prove definitely helpful. After discussing fatigue and the physical factors in industrial hygiene, the authors take up the subject of health service and first aid. Sixty-five pages are devoted to the presentation of occupational intoxication on the basis of a practical chemical classification of the elements and their compounds, both as inorganic and organic substances. After discussing the nature, mode of action, and modes of entry of poisons, the author deals with gaseous, non-metallic, light metallic, and heavy metallic elements.

Organic compounds are subdivided into aliphatic, aromatic, heterocyclic, and metallo-organic compounds. Considerable occupational intoxication can be prevented by the recognition and control of the offending agent, when the engineer contemplates new developments or makes a change in materials or in process. Advice from the medical personnel should be utilized.

In the succeeding chapters the authors deal with chemical burns, oxygen deficiency and asphyxia, dust diseases, respirators, gas masks, etc. An appendix treatment of bandaging, splinting, resuscitation and transportation of the injured concludes the work.

From this book engineering students, engineers, and plant managers should readily gain a working knowledge of industrial hygiene.

D. E. KAVANAUGH, Newark, N. J.

SURGICAL PATHOLOGY OF THE DISEASES OF THE MOUTH AND JAWS. By Arthur E. Hertzler, M.D. Published by J. B. Lippincott Company, Philadelphia, Montreal, London.

This is the most recent of this author's series of Monographs on Surgical Pathology. It follows his usual system of classification and helps to prevent the general surgeon from overlooking any possibilities in his endeavors to make accurate diagnosis of lesions of the mouth and jaws.

Excellent indexes and frequent bibliographical references give the work additional value.

DOCTOR BRADLEY REMEMBERS. A novel by Francis Brett Young. Published by Reynal & Hitchcock, New York. Price \$2.75.

This is a good book by an outstanding novelist, who is also a physician by training. It carries the reader through the periods of rapid advance in medicine and surgery and medical training of the latter nineteenth century. It is refreshing in that Dr. Bradley as a general practitioner with no call on fame, and with less than average ego, portrays with some accuracy the trials of the average doctor in small English industrial communities.

It is recommended for entertainment, for its medical historical virtues, and for some insight into medical economics.

HOW TO CONQUER CONSTIPATION, by J. F. Montague, M.D., Editor-in-Chief of Health Digest, Medical Director, New York Intestinal Sanitarium. Published by J. B. Lippincott Company, Philadelphia, New York, London, Toronto. Price \$1.50.

This book consists of a series of answers to questions which have occurred with frequency in the practice of a specialist in intestinal ailments. Dr. Montague writes interestingly for the layman upon a popular subject. It may be of benefit as a special brochure for recommendation to patients.

CONTACTS AND COMMENTS

ELECTION TO MEMBERSHIP

Complaints often come to the Executive Offices that newly elected members do not receive their Journals. In every instance the reason has been found to be the fact that the State dues have not been paid, or at least they have not been sent to the State Treasurer. In some instances the State dues of a member elected in the Spring are not paid until the following January.

It is often assumed that a physician can be a member of a county society without belonging to the State Society. This point needs clarification by the adoption of an official ruling that the payment of both the State and the county dues is necessary to qualify a physician as a member of a county society.

NEW JERSEY DENTAL SOCIETY

For the first time in its history, the New Jersey State Dental Society has invited official representatives of The Medical Society of New Jersey to participate in the proceedings of its Annual Meeting, which will be held in the Ambassador Hotel in Atlantic City April 19-21, 1939. Dr. D. Ward Scanlan has accepted the assignment for April 19th; Dr. Ralph K. Hollinshed for April 20th; and Dr. Charles Hyman for April 21st.

RABIES

While there is some improvement in the rabies situation in Northeastern New Jersey (Journal, March, p. 171), the situation is still serious. New cases among dogs are constantly being discovered, although no more human cases have been reported. The known sources of infection that have been traced have been homeless dogs who have the disease in a manic form, and wander aimlessly, biting other dogs whom they meet. The public dog-catcher is therefore an important factor in controlling the spread of the disease.

No cases have been reported among cats, although in other epidemics they have been known to spread the disease. It will be wise to include homeless cats in the field of the dog-catcher.

Quarantine of all dogs remains the only practical method of controlling the spread of the disease. Preventive inoculation does not seem to be a certain method of protection; al-

though it may be of value when a dog receives only a slight amount of infective material of low virulence.

MEDICAL HISTORY

Please turn to the editorial on page 195 of this Journal, and to a similar one on page 136 of the March Journal, and read the plan of the medical history project which is sponsored by the State Society. The material which has already been prepared will be shown at the Annual Meeting as an exhibit under the auspices of the Woman's Auxiliary.

Turn also to page 253 and read the inspiring appeal by Mrs. Beir, Chairman of the Art and Historical Exhibit of both The Medical Society of New Jersey and the American Medical Association. Just as New Jersey was the pioneer in establishing a State Medical Society, so also is it the pioneer in a concerted effort to perpetuate the memories of the early leaders and of their successors who developed the system under which the Societies of the other States and the A. M. A. itself is now working with ever-increasing efficiency.

SUSSEX COUNTY BULLETIN

The Sussex County Medical Society has issued Vol. 1, No. 1, of its eight-page Bulletin dated April, 1939, thus becoming the fifteenth society to issue its own publication. It starts off with a three-page presidential greeting by President Spencer, in which he writes:

"The Sussex County Medical Society is breaking its habit of waiting until the larger societies have spoken, and it now intends to make itself heard on every appropriate occasion. The members now feel that officers should not be elected for life; that the President, and not the Secretary should preside; and that trivial matters should be avoided, but every member should be allowed to voice his opinion. By following these principles the Society has undergone a metamorphosis, and has changed from a tadpole which only wagged its tail, into a croaking frog telling the world that it is very much alive.

"This Bulletin should become a tasteful vehicle for the ailments of the Medical Profession of Sussex County."

The Bulletin has three pages of items such as doctors talk about when they meet one another. It is as refreshing as a family letter from home.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

APRIL, 1939

4 Camden	13 Somerset
4 Cape May	14 Atlantic
4 Hudson	14 Salem (Annual Meeting)
11 Bergen	18 Warren
11 Cumberland (An. Meeting)	19 Middlesex
12 Mercer	20 Gloucester
12 Ocean	20 Morris
12 Union (Annual Meeting)	25 Hunterdon (Annual Meeting)
13 Burlington	26 Monmouth (Annual Meeting)
13 Essex	
13 Passaic	

MAY, 1939

2 Camden (Annual Meeting)	11 Essex (Annual Meeting)
2 Hudson (Annual Meeting)	11 Passaic (Annual Meeting)
9 Bergen (Annual Meeting)	12 Atlantic (Annual Meeting)
9 Sussex (Annual Meeting)	12 Salem (Social Meeting)
10 Mercer	17 Middlesex
10 Ocean (Annual Meeting)	18 Gloucester (Annual Meeting)
10 Union	18 Morris
11 Burlington	24 Monmouth

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The regular monthly meeting of the *Cumberland County Medical Society* was held in the reception room of the Nurses' Home in the Millville Hospital on March 14, 1939.

Two applications for membership were received.

WOMAN'S AUXILIARY

The formation of a Woman's Auxiliary to the Medical Society was discussed; and Drs. Mary Bacon, Charles Cunningham, and J. S. Knowles were appointed a committee to ascertain the attitude of the doctors' wives toward the Auxiliary.

SCIENTIFIC

Dr. Ernest L. Shore, Atlantic City, discussed the subject of socialized medicine with special reference to the methods and results of its practice in England.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held March 9th, 1939, at nine p.m. in the Academy of Medicine in Newark, with President Kraker presiding.

NUMBER OF MEMBERS

President Kraker announced that the society now has 911 active members without counting the associate members. This is an increase of sixty-nine over last year.

CHILD AND MATERNAL WELFARE

Dr. Chester Broyn read a report of the Child Welfare and Maternal Welfare Committees in which they suggested better care for the new born in hospitals. The society voted the approval of the recommendations.

SCIENTIFIC

This being the meeting set aside for the discussion of *cancer*, the first speaker was Dr. A. R. Cassili, of Elizabeth, whose topic was "Organization and Function of a Cancer Clinic". He said that early diagnosis and treatment are the two important points to keep in mind. Proper training in tumor pathology and biopsies is all-important. He said that in Elizabeth a clinic is being conducted, the cost of which, including equipment and building, is only \$25,000. It has the moral support of the Memorial Hospital of New York City. It takes care of both private and indigent patients. All physicians have access to the clinic.

Dr. E. W. Sprague, Newark, took for his topic "Surgery in the Treatment of Cancer". He stressed the importance of an early diagnosis, and when an operation is needed for diagnosis, such an operation is warranted. Radical surgery is all-important, and until we find other means surgery must be done.

Dr. Milton Friedman, Newark, spoke on "Radiation Therapy in Cancer". He said on investigation, it is surprising how much radium and x-ray equipment there is in New Jersey. He said it is the *workman* rather than his tools that is important. Radiation should be employed so as to destroy the cancer completely.

Dr. Harrison Martland gave a "Demonstration of Cancer Specimens Through the Episcopes". He presented many gross specimens on the screen, and explained them fully. He had an especially fine collection of cancers of the lung. This condition, he said, is on the increase.

The following were all elected to membership: Active—Martin Castellano, Newark.

Reinstatement—Robert M. Levison, Newark.

Transfers—

Benoit C. Isaac, Orange, from Middlesex County

Harold C. Tooker, Bloomfield, from Massachusetts Medical Society.

Associate—

Benjamin Gencher, Caldwell
Adolph S. Rost, Orange
Max Strauss, Irvington
Harrison Wesson, Montclair.

PHYSICIANS' CLUB

On Wednesday evening, March 8th, 1939, a special meeting of the *Physicians' Club of Essex County* was held for the purpose of meeting the legislators of our county and talking over Assembly Bill-210 with them, eight being present.

Dr. Frank Bien, Chairman of the Legislative Committee, gave the reasons why he felt this was a good bill and should receive the support of every representative. He was followed by Dr. E. Zeh Hawkes, who gave an excellent and clear description of the bill. Dr. John Condon gave the Medical Examiners' viewpoint. Drs. Alfred Stahl and David Kraker made added remarks as to the worthiness of the bill presented.

Dr. Lovell, President of the club, then called upon the several legislators, and asked them to express their praise or criticism of the Bill. They all seemed to feel that it was a good Bill, and all praised the clause for higher standards. Only one thought that the citizenship clause might hinder its progress in becoming a law.

All in all, it was a big success. A dinner was served at the close of the meeting.

ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The *Academy of Medicine of Northern New Jersey* celebrated its twenty-eighth anniversary at its stated meeting held Thursday, March 16th, at the Academy, 91 Lincoln Park, South, Newark. President Henry C. Barkhorn called the meeting to order at 9 p. m.

The report of the *Nominating Committee* (Drs. William H. Areson, Chairman; Royal A. Schaaf, and Sidney C. Keller) was read as follows:

President (two years), Charles M. Robbins, M.D., Newark

Vice-President (two years), Edward W. Sprague, M.D., Newark

Secretary (two years), Franklin J. Tobey, M.D., Newark

Treasurer (two years), Lee W. Hughes, M.D., Newark

Trustees (two) (five years): Harry B. Epstein, M.D.; Henry C. Barkhorn, M.D., Newark

Committee on Admission (five years), P. Du-Bois Bunting, M.D., Elizabeth

Committee on Library (five years), Julius Gerendasy, M.D., Elizabeth.

The committee also recommends that as Dr. Sprague is nominated for Vice-President, his position as Statistical Secretary be declared vacant.

Dr. Aaron E. Parsonnet was elected a Benefactor, in appreciation of his excellent work in rebinding and preserving the valuable books of the Academy.

Dr. Barkhorn announced that Dr. Foster Kennedy would be the guest speaker at the meeting

for the laity Thursday, April 27th; and that the stated meeting for May would be held on Tuesday, May 23rd, in honor of Dr. Edward J. Ill's eighty-fifth birthday. He invited all those present to come and bring their friends.

Dr. Barkhorn introduced Oscar Riddle, Ph.D., Director of the Department of Genetics, Carnegie Institution of Washington at Cold Spring Harbor, New York. Dr. Riddle's paper, "Our Uncontrollable Governor—the Pituitary Gland", was the story of the known and unknown influence the pituitary gland exerts upon all the other glands of internal secretion, and their effort in checking the pituitary gland. Dr. Riddle illustrated his scientific data by lantern slides. Following the meeting, the Woman's Auxiliary to the Essex County Medical Society served a collation.

Program of the Academy of Medicine of Northern New Jersey for May, 1939:

Council	Thurs., May 4
Obstetrics and Gynecology	Thurs., May 4
Eye, Ear, Nose and Throat	Mon., May 8
Medicine and Pediatrics	Tues., May 9
Stated Meeting	Tues., May 23

(Usual date of the stated meeting changed to Dr. Ill's birthday.)

Obstetrics and Gynecology, Thursday May 4, 1939, 8:45 p. m.

Election of Officers:

Paul J. Kreutz, M.D., Elizabeth, Chairman

Robert R. White, M.D., East Orange, Secretary

Paper: "Obstetrical Analgesia"

Louis H. Douglass, M.D., Professor of Clinical Obstetrics, University of Maryland

Eye, Ear, Nose and Throat, Monday, May 8, 1939, 8:45 p. m.

Clinical Program, Newark Beth Israel Hospital, 201 Lyons Avenue, Newark

Medicine and Pediatrics, Tuesday, May 9, 1939, 8:45 p. m.

Paper: "Diarrheas and Dysenteries of the Adult. New Aspects of Diagnosis and Management"

Moses Paulson, M.D., Associate in Medicine, Johns Hopkins University

Paper: "Surgical Therapy for Ulcerative Colitis" Burrill B. Crohn, M.D., Mt. Sinai Hospital, New York City

Stated Meeting, Tuesday, May 23, 1939, 8:45 p. m.

Tribute to Edward J. Ill, M.D., on his eighty-fifth birthday

Wells P. Eagleton, M.D.

Address of the Retiring President

Henry C. Barkhorn, M.D.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Homestead Coffee Shop on Thursday evening, March 16, 1939, at nine o'clock, with thirty-two members and six visitors present. President William Crain, of Woodbury, presided.

The delegates to the various county societies reported on their attendance at the meetings and spoke of interesting facts concerning visitations.

POST-GRADUATE

Dr. Diverty reported that the course on post-graduate instruction being held in Camden was well attended and that the membership of the Gloucester County Medical Society was well represented.

TUBERCULOSIS

Dr. Knight, of the Public Health Committee, reported that five of the six high schools in the county will receive the tuberculosis testing and x-raying. This work will cover the pupils in all the classes and the employees of the school board in the high schools.

VENEREAL DISEASE

Dr. Knight also reported that the venereal disease clinic has grown so rapidly that it will soon be necessary to have more help to take care of the work.

LEGISLATION

Dr. W. J. Burkett, reporting for the Legislative Committee, said that the Uniform Medical Practice Act had been introduced as Bill A-210 and that it had been referred to the Public Health Committee for study. He briefly outlined the provisions of the act and said that the representatives of Gloucester County in the State Legislature were strongly in favor of the passage of the bill.

Dr. William J. Carrington, President of the State Medical Society, was present at the meeting and reviewed the Wagner Health Act of 1939. In his review of the bill he said that it was unsound in principle and unworkable in practice.

The society went on record as being opposed to the bill in its present form, and instructed the Secretary to write our national representatives and ask them to carefully study the bill, and to register our objections to it.

SCIENTIFIC

The Committee on Scientific Program presented Dr. P. Brooke Bland, Emeritus Professor of Obstetrics at Jefferson Medical College, who spoke informally on the subject of "Obstetric Hemorrhage, Its Significance and Management". Dr. Bland presented the subject in a unique manner which was most impressive and instructive to those listening.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, March 7, 1939, at 9:30 p. m. The meeting was called to order by the President, Dr. Reeve L. Ballinger, at 9:30 p. m.

UNFINISHED BUSINESS

Dr. R. L. Ballinger suggested that we have a discussion on Newspaper Advertising as advocated by The Medical Society of New Jersey. Dr. W. J. Snyder

explained that this advertising, which each county in the State is supposed to advocate, would cost Hudson County approximately \$3000, and each member of this society would have to be assessed \$5.00 or \$6.00 a year.

This matter was discussed in detail by Drs. Shapiro, Alter, Stockfish, Barbarito, Spence, and Caltery. The society voted not to adopt the project.

SCIENTIFIC SESSION

Dr. Ballinger introduced Dr. George A. Blakeslee, Professor of Neurology and Psychiatry, New York Post-Graduate Medical School and Hospital, whose subject was "Common Neurological Entities in General Practice".

Discussors: Drs. Stockfish, T. White, Ginsberg, Alpert, Flicker, Finger, Rosenstein. Terminated by Dr. Blakeslee.

MEMBERSHIP COMMITTEE REPORT

Dr. W. T. Callery, Chairman of the Membership Committee, stated that we now have a paid-up membership of 386 members, and urged all those who did not pay their dues to do so immediately. (Note: As of March 15th, the paid-up membership is 432.)

POST-GRADUATE COMMITTEE

Dr. Ballinger said that, at the last Executive Committee meeting, a communication on post-graduate work in conjunction with The Medical Society of New Jersey and Rutgers University was referred to Dr. Thomas J. White, Chairman of the Post-Graduate Committee, for report at this meeting.

Dr. T. J. White stated that he would have a complete report by the next regular meeting of the society.

NOMINATING COMMITTEE

Dr. A. J. Conty reported that the Nominating Committee met Saturday, March 4th, and made nominations for the annual election to be held during the May meeting.

MERCER COUNTY

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on March 8, with Vice-President Elias presiding.

SCIENTIFIC

Dr. William A. Lell, Associate in Bronchoscopy, University of Pennsylvania, gave a lecture on "Laryngoscopy", illustrated with moving pictures of the larynx in its natural color, in both health and disease.

NEW MEMBER

Dr. Paul E. Smith of the New Jersey State Hospital Staff was elected to active membership.

FEBRUARY MEETING

The entire session of the regular meeting held on February 8, 1939, was devoted to a discussion of important changes in the Constitution and By-Laws which will come up for adoption at a later meeting.

Drs. Larsson and Meehan were elected to active membership, and Drs. Fritz and Pittman, to associate membership.

JANUARY MEETING

At the regular meeting of the Mercer County Medical Society held on January 11, 1939, Dr. Charles Mazer, Chief of the Gynecological Department of Mt. Sinai Hospital, Philadelphia, gave an address on "Sterility", illustrated with lantern slides.

CANCER CONTROL

Dr. Chianese gave a comprehensive report on the work of the Cancer Control Committee.

MIDDLESEX COUNTY

Howard Dieker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, N. J., on March 15th, 1939. Dr. N. N. Forney, President, called the meeting to order at 9:30 p. m.

NATIONAL LEGISLATION

Dr. Carrington, President of the Medical Society of the State of New Jersey, gave a detailed résumé of the "Wagner Act". Following his paper there was a general discussion of the subject, but no definite action was taken by the society.

SCIENTIFIC

Dr. George Pack, Attending Surgeon, Memorial Hospital, New York City, gave an interesting and instructive talk on "Recent Advances in the Treatment of Cancer".

Because of the lateness of the hour no business was transacted after the scientific session. A motion was then passed that we devote the whole of the next meeting to business matters.

The meeting was adjourned at 11:30 p. m.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

EXECUTIVE COMMITTEE MEETING

A meeting of the *Executive Committee of the Monmouth County Medical Society* was held on Monday evening, March 13th, 1939, at the Monmouth Memorial Hospital, Long Branch. The meeting was called to order by the President, Dr. C. Byron Blaisdell, at nine o'clock. Members of the committee present were: Drs. Blaisdell, MacKenzie, Moffat, Pregnell and Featherston.

LEGISLATION

A communication was received from Assemblyman Harold McDermott relative to Senate Bill S-171. This bill, which has the approval of the State Legislative Committee, requires not only physicians, but pharmacists and hospital heads, to report venereal disease patients to the State Department of Health. Mr. McDermott stated that the purpose and the object of the law were excellent, but he questioned one provision therein. Mr. McDermott has been advised that Dr. Robert Sellers, of Newark, has taken steps for the deletion of the provision of the bill.

After some discussion of Senate Bill A-210 (Uniform Medical Practice Act), the Secretary was instructed to advise the three Monmouth County Legislators as to our interests in this bill.

MEMORIAL OF DR. GOSLING

President Blaisdell reported the death of Dr. W. W. Gosling. (See obituary on page 242.)

PROGRESS OF THE COUNTY SOCIETY

Committees are now meeting to summarize the progress made in the year's work in time for the next meeting. Some good strides have been made in a few fields, some having their work well under way, and others have yet to develop an active program. It is increasingly apparent that the personnel of a committee must be maintained with only fractional changes from year to year in order to have an understanding of the committee's problems. It is also increasingly apparent that there is a great necessity for aligning the county committees' work with the State program.

In the next month's bulletin reports of all committees will be included in a large annual number; and this, it is hoped, will be kept as a part of a permanent library to be built up by the society.

LIBRARIAN

At the next meeting, the appointment of a Librarian will be made to lay plans for the library's future development and to begin the accumulation of papers read before the society, newspaper clippings, committee reports, etc. This might well be coordinated with any historical data of the society which may be available, and which will develop as time goes on. It seems advisable to have some records kept of the society's current growth and activities.

LEGISLATION

A detailed report on medical legislation was made, together with a statement of the favorable attitude of the society toward the Medical Practice Amendments.

MONMOUTH COUNTY MEDICAL SOCIETY

The regular monthly meeting of the *Monmouth County Medical Society* was held on Wednesday evening, March 22nd, 1939, at the Nurses' Home, Fitkin Memorial Hospital, Neptune. The meeting was called to order by Dr. C. Byron Blaisdell, President, at about 9 p. m. There was an unusually large attendance.

SCIENTIFIC

The scientific program of the evening was under the auspices of Dr. Harold Kazmann, of Long Branch, who introduced the speakers, Dr. Daniel R. Mishell of St. Mary's Hospital, Orange, N. J., and Dr. Leon Motyloff, Pathologist, Women's Hospital, New York.

The topic of discussion was the "Practical Value of Endometrial Biopsy", particularly as applied to sterility. The paper was illustrated by lantern slides.

The discussion was participated in by Drs. Carlos Pons, O. D. Parry, and William Shanik.

A motion was adopted permitting the society to accept paid advertising for the monthly bulletin.

The application of Dr. Samuel Bar, of English-town, was voted upon and he was unanimously elected to membership.

Dr. O. K. Parry introduced a memorial of the late Dr. Walter Gosling, Red Bank. It was unanimously adopted, and a copy of said resolution will be sent to his family.

The meeting was adjourned about 11:30 p.m., following which a collation was served by the hospital.

MONMOUTH MEMORIAL HOSPITAL, LONG BRANCH

The monthly meeting of the Staff of the Monmouth Memorial Hospital, Long Branch, was held on Wednesday, March 8th, 1939. An unusually large attendance was present.

Dr. Victor Knapp, Asbury Park, presented a review of pneumonia, based on a study of the charts of this hospital for the past six years. Dr. Knapp made a very critical analysis of the pneumonia situation, as well as comments upon the newer forms of specific therapy.

The discussion that followed was an unusually animated one which was led by Drs. M. G. Hermann, Samuel Edelson, Joseph Wiener, and Frank Altschul.

The meeting was adjourned about 11:30 p.m.

FITKIN MEMORIAL HOSPITAL

The regular monthly meeting of the hospital was held on Monday night, March 20th, 1939, in the Conference Room.

Routine business of the evening was conducted under the auspices of Dr. Parry in the chair.

Drs. Prout, Featherston, and Pons presented a case of asystematic typhoid fever with practically no temperature, and none of the characteristic symptoms; but with positive stool culture and positive widal reaction.

Dr. Louis Albright, of Spring Lake, presented a case of carcinoma of the lung.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular meeting of the *Morris County Medical Society* was held the evening of March 16, 1939, at the New Jersey State Hospital at Greystone Park, with President Thomas presiding.

VENEREAL DISEASE CLINIC

The Executive Committee reported that it had recommended the appointment of Dr. A. B. Coultas to be the physician in charge of the Venereal Disease Control Clinic in Madison.

CANCER CONTROL

The Executive Committee also submitted a report on three recommendations of the Committee of the Curie Institute for Cancer Control:

1. Regarding the plan that four beds in the three general hospitals in the county be set aside for incurable cancer cases, the Executive Committee felt this is impracticable, and that the beds should be provided in the Welfare House rather than in the hospitals.

2. Recommending that 200 mg. of radium be rented at a cost of \$1,000 to be paid for by lay groups, or the County Board of Freeholders. This was unanimously approved, with the suggestion that further consideration be given to the proper use of this radium.

3. Regarding the proposition that \$21,000 be raised for additional x-ray equipment in the three hospitals, the Executive Committee considered that this plan is impracticable, and that the problem of ownership of the additional x-ray equipment would become involved.

SCIENTIFIC

The speaker of the evening was Dr. Anthony F. DePalma, Assistant Surgeon of the New Jersey Orthopedic Hospital, whose topic was "Low Back Pain". The speaker discussed the several causes and their appropriate treatment. He differentiated the static type found in long, lank persons with poor tone and hyper-extended spines, from the type caused by unstable lumbo-sacral joints, and that caused by transitional first sacral segments. The speaker also described cases in which the intervertebral disc herniates back into the neural canal; and showed x-ray films of the various changes in the lower spine, and of cases in which lipiodol had been injected.

It was decided to omit the April meeting because of a possible Tri-County meeting early in May.

OCEAN COUNTY

J. Bruce Henriksen, M.D., Reporter

The regular meeting of the *Ocean County Medical Society* was held at the Sunset Cabin, Lakewood, on March 8th, 1939, with the President, Dr. Emanuel Sickel, presiding. Those present were Drs. Blumberg, Bunnell, Dodd, Frazee, Gaumer, Goldstein, Halbach, Herbener, Henriksen, Hogan, Ivory, McIlvaine, Obert, Schneider, Sickel, Szold, Taylor, Thompson, and Towbin.

One proposal for membership was received.

ROYAL PINES HOSPITAL

Dr. Halbach reported for his committee that an investigation had been made of the Royal Pines Hospital, which is located in Pinewald, a few miles south of Toms River. The hospital was found satisfactory to the committee; which recommended that our society approve it to the American Medi-

cal Association for listing in its register. (Jour., Feb., 1939, p. 132.) On motion, the recommendations were accepted.

Dr. Herbener reported the activities of the Welfare Committee and Dr. Halbach supplemented the committee's report by adding that the Welfare Committee of the State Society was considering the matter of the Lakehurst situation.

TREASURER'S REPORT

The Treasurer reported by proxy a balance of \$288.65 in the treasury with outstanding bills to the extent of \$16.85. Delinquent members were urged to pay their current dues.

AMENDMENTS TO CONSTITUTION

It was regularly moved and seconded that the proposed amendments to the Constitution of The Medical Society of New Jersey, which shall read as follows, be approved:

1. Article V, entitled "House of Delegates", shall read, "The House of Delegates shall be the legislative body, and shall hear appeals from the decisions of the Judicial Council, and shall consist of the Fellows, Officers, and Delegates".

2. Article VII, entitled "Councilors", shall read, "The House of Delegates shall organize five (5) councilor districts within the State. This Society shall elect one (1) councilor from among the membership (changed from delegates) of each such district; and these elected councilors collectively shall constitute the Judicial Council." The Secretary was instructed to refer this matter to our delegates to the State Society.

SCIENTIFIC

Dr. Wallace Dyer, of University of Pennsylvania, gave an interesting talk upon the practical treatment of diabetes. The subject of diabetes was freely discussed by the members present.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at Hope Dell (County Welfare Home at Preakness) on Thursday evening, March 9th, 1939, at 9 p.m. President L. G. Shapiro presided.

ADVERTISING

Dr. Okin, Chairman of the Publication Committee, read the contract in which the Society agreed to pay an advertising solicitor a percentage of the advertising for the Bulletin he would bring. This contract was approved.

ELECTION

Dr. Walker, Chairman of the Nominating Committee, then nominated the following men as delegates and alternates to the State meeting in June:

DELEGATES

Francis W. Ash	Wright MacMillan
Thomas A. Clay	Andrew F. McBride
A. J. Delario	Lester F. Meloney
Armand De Rosa	Charles J. Murn
Norman M. Dingman	Louis G. Shapiro
Samuel Ginsburg	William Spickers
Theodore K. Graham	Fred Vosburgh
Wayne W. Hall	Harold G. Walker
Charles Harreys	Hans Wassing
Sigurd W. Johnsen	Harry Wolfson
Morris Joseph	J. Allen Yager
John E. Leach	

ALTERNATES

James Allen	Alfred Meneve
George Becker	Joseph E. Mott
Henry Bongiorno	Irving Okin
Forrest Chilton	E. C. Reynolds
P. J. DeBell	C. D. Smith
Irving Ehrenfeld	William Sullivan
Charles Keppler	John J. Szymanski
Samuel Kleiner	L. E. Thron
Sidney Levine	Francis H. Todd
Thomas E. Manly	Samuel Yacknin
William Marrocco	John S. Yates
Kenneth McCamey	

Member of State Nominating Committee, Andrew F. McBride; Alternate, Charles J. Murn.

NEW MEMBERS

The following new members were elected:
For Active Membership: Irene O. Thomas, Hawthorne.

For Associate Membership:

Samuel J. Della Penna, Pompton Lakes
F. Albert Graeter, Passaic
Philip Oppen, Paterson
Elroy Pasternack, Passaic

Dr. Hall read a resolution on the retirement of Dr. Cogan from practice in Paterson which had been proposed by Dr. Nye and Dr. Sutherland.

GROUP HOSPITAL PLAN

Dr. McBride spoke on the group hospital plan, and urged its use by more people.

ADVERTISING

A statement was read from the Committee on Public Relations of the State Society on advertising by the County Medical Society in newspapers. Dr. Marsh discussed the proposal, and thought that each county should decide what to do. The matter was tabled for discussion and action at the next meeting.

SCIENTIFIC

Dr. Spickers, Chairman of the Passaic County Cancer Committee, introduced Dr. Frank Adair, Attending Surgeon, Memorial Hospital, New York City. His subject was "Cancer of the Breast, Its Diagnosis and Treatment".

Dr. Adair complimented Passaic County on its cancer activity, and said that it should act as a model throughout the country. He showed figures

on the studies of cancer patients for the past twenty years, and pointed out that patients were coming to the physician earlier for cancer.

A large number of members heard the talk.

A collation was served after the meeting.

PASSAIC COUNTY CANCER COMMITTEE

The Passaic County Cancer Committee, a non-profit, philanthropic, educational organization to combat cancer, and a unit of the American Society for the Control of Cancer, has been organized. Its purpose is to seek a reduction in both the incidence and the death rate of cancer in Passaic County. Pioneer work in organizing the committee was done by the Passaic County Medical Society.

Dr. William Spickers, of Paterson, has been elected chairman of the committee, and Dr. James S. Gallo, of Haledon, secretary. This new group is not to be an adjunct of the County Medical Society, but is to be an independent agency which will include non-medical persons interested in cancer control. At present, the committee consists of medical men from all over the county.

The activities of the committee will include efforts to increase and improve facilities for the treatment of cancer in the county; to serve as an ethical advisory service for all persons who wish to learn where they can obtain competent medical advice or treatment concerning suspected or actual cancer; educational efforts intended to encourage early diagnosis and treatment of cancer, and the presentation to the public of information concerning the prevalence and death rate of cancer in Passaic County and ways of reducing them.

An educational program of this type has resulted in a decrease in the incidence and death rate of cancer in Massachusetts. While the incidence and death rate of cancer in other states have been rising, they have been decreasing in Massachusetts.

The local committee has already organized a monthly symposium for the medical men of the county. Each symposium is held in a different hospital, thus covering the entire county and giving all medical men an opportunity to hear of the latest developments in this field.

Exhibitions and lectures are being organized. An information bureau is in operation at the County Administration Building, Hamilton and Ward Streets, Paterson. Pamphlets are ready for distribution. Any lay organization wishing to obtain a speaker on cancer should communicate with the information bureau.

SOMERSET COUNTY

H. B. Day, M.D., Reporter

The February meeting of the *Somerset County Medical Society* was held on February 8th, 1939, in the Nurses' Home of the Somerset Hospital. President Edgar Flint presided, and there were about thirty members and guests present.

MONTHLY MEETINGS

By a majority vote of those present it was decided to have monthly meetings from September to June and to alternate business and scientific sessions. Meetings will be held at 8:30 p.m. on the second Thursday of each month. Heretofore the society has met five times a year.

SCIENTIFIC

Dr. A. A. Lawton reported on maternal welfare and prenatal care in Somerset County; and Dr. A. W. Bingham, East Orange, addressed the society on the State program for maternal welfare and prenatal care.

Following adjournment refreshments were served by the nurses of the Somerset Hospital.

The March meeting was held on the eighth of the month with President Flint presiding and forty members and guests present.

SCIENTIFIC

The meeting was devoted entirely to a scientific program. The speaker for the evening was Dr. F. P. Willey, Assistant Cardiologist to the Presbyterian Hospital, Newark, member of the Research Group of the Montefiore Hospital, New York, and Associate Attending Cardiologist to St. Michael's Hospital, Newark. Dr. Willey chose for his subject "Coronary Disease", and his address was interesting and practical.

Refreshments were served by the nurses of the Somerset Hospital.

UNION COUNTY

Ronald J. Walsh, M.D., Reporter

The regular monthly meeting of the *Union County Medical Society* was held at the plant of the Ciba Pharmaceutical Company at Summit on March 8th, 1939, with the President, Dr. H. Abel, presiding over a very large attendance.

SCIENTIFIC

The scientific program consisted of a detailed and protracted symposium on "The Essential Features of Male Hormone Physiology and Therapy". The chemistry and physiology of the male hormone was thoroughly discussed by Dr. E. Oppenheimer; this was followed by a moving picture showing the differentiation of pseudo from true cryptorchidism, and finally the essential features of the male hormone therapy were elaborated by Dr. R. MacBrayer.

NOMINATING COMMITTEE

Because of the length of the program and the lateness of the hour there was no discussion, and for the same reasons, the business of the meeting was completed with admirable dispatch. The Nominating Committee for the year was elected by acclamation, and consists of Dr. F. W. Lathrop, Dr. Charles Schlichter and Dr. William Boozan.

After the meeting the society was served a collation.

THE WOMAN'S AUXILIARY

THE ART AND HISTORICAL EXHIBIT OF THE WOMAN'S AUXILIARY

By MRS. ILY R. BEIR, Atlantic City, N. J.

The Woman's Auxiliary to The Medical Society of New Jersey submitted the following report to the Board meeting on March 13, 1939, in Newark:

During the last four years The Medical Society of New Jersey has entrusted to this committee the collection, recording, and exhibition of data and objects bearing on the Medical History of New Jersey; and this work has steadily grown until it has become a major objective of our Auxiliary. This year, under the leadership and active sponsorship of Dr. William J. Carrington, the formation of the Archives of The Medical History of New Jersey has been made a major objective of The Medical Society of New Jersey; and in doing our part we can be of direct assistance in carrying on the project.

Where previous chairmen of County Medical History committees were doing good work and were willing to continue, they should be reappointed in order to avoid the lag incident to the formation of new committees, and their instruction in a type of work new to them.

I beg that all County Presidents make a survey of the work being done by their Medical History committees, and take pride in seeing that their county presents some part of its wealth of Medical History at the exhibition, so that our Auxiliary work may merit even greater respect by The Medical Society of New Jersey, and that the records of our State may become better known to the medical world.

Every county has had many noted doctors. Their biographies may be gotten from records

and descendants. These records are the foundations from which our medical organizations and facilities have sprung, and the knowledge of how those men handled their problems may give us much wisdom in settling our own. Such records should be sought for and preserved.

Very shortly letters and entry blanks will be sent to every County Medical Society, to its Auxiliary, and to previous and prospective exhibitors. I do hope all of you will be active in entering your own interesting articles, and in soliciting entries from your friends, whether of art, hobbies, or medical history.

We will have our exhibition in the Sun Porch, on the Lounge Floor of Haddon Hall. It is a very beautiful room, fully enclosed, with fine daylight and artificial lighting, and will be locked at night. It has plenty of wall space, and is near the Auxiliary meeting room and the Scientific Exhibits. Our Tea will be held in the exhibition room on Wednesday afternoon, following the talk on New Jersey Medical History which Dr. Frank Overton, Editor of The Journal, has consented to give us.

It is especially desirable to have much Medical History material presented, so that it will be available for the Exhibits of the Woman's Auxiliary of the American Medical Association, of which I have the honor of being chairman also, during the National Convention in St. Louis, May 15-19, 1939. Because of the early date of the A. M. A. meeting, I do hope I may have such material prepared and given to me early in May.

THE A. M. A. WOMAN'S AUXILIARY EXHIBIT, 1938

By MRS. ILY R. BEIR, Atlantic City, N. J., National Chairman of Exhibits

The exhibit of Art and Medical History of the A. M. A. Woman's Auxiliary in 1938 in San Francisco was the show window of the National Woman's Auxiliary where were displayed the latest models and styles of Auxiliary activity throughout the nation. Exhibits were sent by twenty-six states, although there

were few from the Eastern States, owing to their great distance from the exhibit city.

There were several exhibits of maps, posters, and placards showing the growth of the Auxiliary of the several states.

California had a large exhibit of Braille books for the blind, and charts of legislative

activities. It also showed examples of charitable work, such as layettes and hospital dressings; and charts of medical activities such as medical economics, health education, and disease prevention.

The State of Washington had a steeplechase model that showed the pitfalls that were overcome in securing the passage of the Basic Science Law of the State.

Utah had a large book of Mother Goose rhymes that were parodies on various modern forms of quacks.

The New Jersey exhibit consisting of two posters on health education, a State Auxiliary program, and our Medical History of New Jersey work was outstanding and excited the greatest of interest because of its detail and amplitude, and the evidence of the ancient beginnings of New Jersey Medical History. The exhibit included photostates of the first meet-

ing of The Medical Society of New Jersey in 1766, photos of groups at early meetings, books on our Medical History, folders of biographies, lists of medical families, and other data prepared by County Auxiliary Medical History committees. I am advised that, because of our exhibit, several states will have medical history exhibits at the 1939 convention. One other state had a Medical History exhibit, but it was only the biographies of the doctors of one county; however, it was a good beginning.

The work of the Woman's Auxiliary, as evidenced by these exhibits, shows that it is a large and potential force that is capable of great service if wisely lead. In addition to their provision of the social and cultural amenities, the wives of medical men are demonstrating their willingness and ability to be of great assistance to the doctors' organizations in a serious way.

Burlington County

Reported by Mrs. Freeman W. Metzger, Riverside

The *Woman's Auxiliary to the Burlington County Medical Society* held a luncheon and business meeting at Boxwood Lodge, Lumberton, on November 7, 1938. Mrs. Don Epler, President of the Woman's Auxiliary to The Medical Society of New Jersey, was our speaker and guest.

A business meeting was held at the home of Mrs. Daniel Reimer, Mt. Holly, on December 5, 1938.

The first meeting for 1939 was held at Newlins' Restaurant, Moorestown, on January 9, 1939. Mrs. Rogers, Past State President of the Woman's Auxiliary, gave an inspiring talk.

A business meeting was held February 6, 1939, at Zurbrugg Hospital, Riverside, followed by a tour of inspection of the hospital.

The new officers for the ensuing year were installed at the March meeting. Mrs. Carlton Hogan was installed for a second term as President. The other officers for the ensuing year are as follows:

President-Elect, Mrs. Luis Viteri
First Vice-President, Mrs. W. C. V. Wells
Second Vice-President, Mrs. Freeman W. Metzger
Secretary, Mrs. E. Vernon Davis
Treasurer, Mrs. Joseph Kuder

Committee chairmen appointed were as follows:

Membership, Mrs. Dean H. LeFavor
Public Relations, Mrs. R. I. Downs
Program, Mrs. J. Howard Hornberger
Widows and Orphans, Mrs. W. C. V. Wells
Legislation, Mrs. Marcus Newcombe
Arts and Hobbies, Mrs. Daniel Reimer
Publicity, Mrs. Freeman W. Metzger

The initial plans for a *Health Institute* dated for May 2, 1939, were discussed. It will be held in Mt. Holly High School, and will replace the customary

public relations tea held each spring by the Auxiliary. The institute will be open to the public, and an all-day program with authoritative speakers is being arranged.

The Auxiliary is arranging to contribute a full-length mirror to the Physiotherapy Department of the Burlington County Hospital to help crippled children in doing their exercises.

A luncheon and business meeting of the State Entertainment Committee was held at the home of Mrs. J. Howard Hornberger, Roebbing, Tuesday, February 28, 1939. Following the luncheon the committee discussed plans for the entertainment at the convention with Mrs. Don Epler, President of the Woman's Auxiliary to the State Medical Society.

The committee consists of the following members: Mrs. J. Howard Hornberger, Chairman; Mrs. Dean LeFavor, Vice-Chairman; Mrs. R. I. Downs, Mrs. E. Vernon Davis, Mrs. Gerald E. McDonnel, Mrs. Carlton Hogan, Mrs. Freeman W. Metzger.

Camden County

Reported by Mrs. George B. German

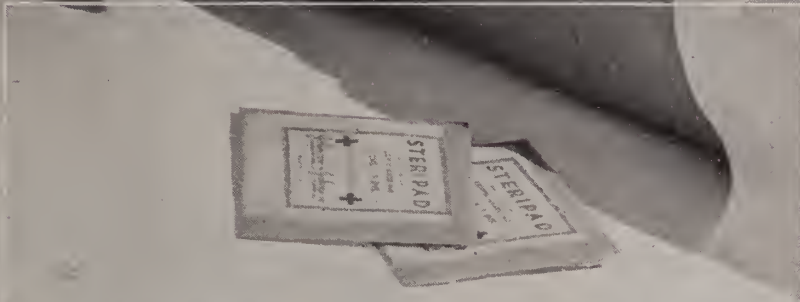
The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on Tuesday afternoon, March 7th, 1939, at the home of Mrs. Wesley Jack, President, with forty-six members present.

Dr. Thomas K. Lewis gave a talk on "What Every Doctor's Wife Should Know". It was most enlightening and helpful in these turbulent times when legislative medicine is little understood.

Mrs. Lewis R. Dick, of Philadelphia, gave some readings.

After the meeting tea was served with Mrs. Joseph Roberts and Mrs. A. Haines Lippincott pouring.

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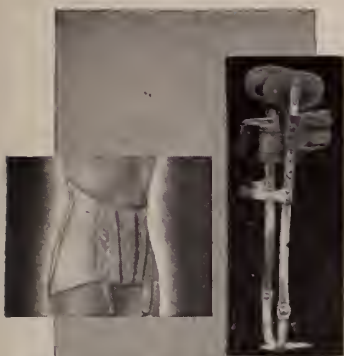
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Located in the Goffe Hill Section of Bergen County, New Jersey, the Christian Sanatorium for the past 25 years has cared in an ever increasing number for Mental and Neurological patients.

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The park-like formation of the lay-out the restful surroundings,—the trained attendants and nurses,—the hydro-therapy,—physio-therapy and occupational re-education,—the marvelous creature-comforts of each patient,—the splendid cuisine, and individual dietetic provisions, all work together to attain a great success in having patients return home physically and mentally improved.

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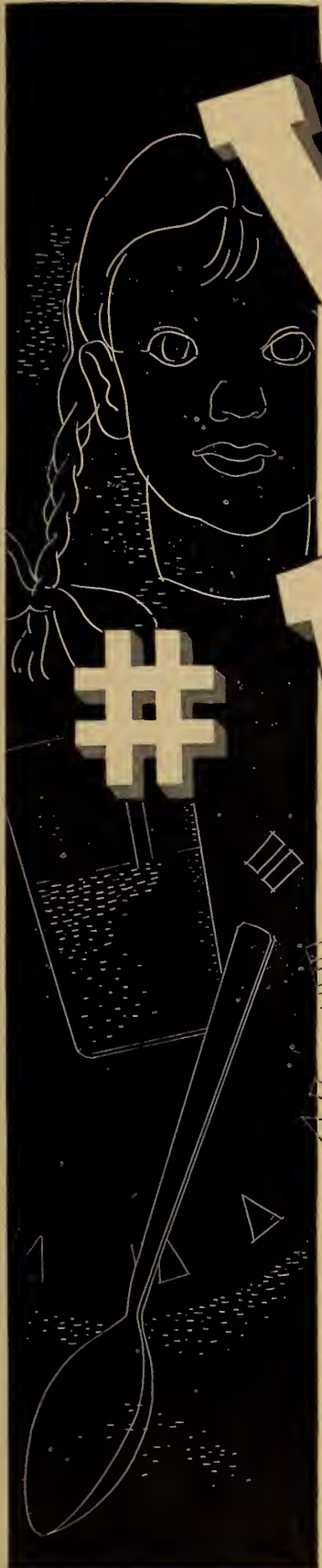
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of

The Medical Society of New Jersey

For the Year 1939

THE MEDICAL SOCIETY
OF MEDICINE
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Supplement to The Journal of The Medical Society of New Jersey, April, 1939

OFFICIAL LIST
OF THE
FELLOWS AND MEMBERS
OF
THE MEDICAL SOCIETY OF NEW JERSEY
FOR THE YEAR 1939

FELLOWS OF THE MEDICAL SOCIETY OF NEW JERSEY

"THE FELLOWS ARE THE EX-PRESIDENTS OF THE SOCIETY." (Constitution, Art. IV., Sec. 2)
Date of Election

1. 1766—ROBERT MCKRAN, Perth Amboy, July 13, 1732—Oct. 17, 1767. Pastor and Physician. Founder of State Society.
2. 1767—WILLIAM BURNET, Newark, Dec. 2, 1730—Oct. 7, 1791. Army Surgeon and Member of Congress. Founder.
3. 1768—JOHN COCHRAN, New Brunswick, Sept. 1, 1730—Apr. 6, 1807. Hospital Director in Revolution. Founder.
4. 1770—NATHANIEL SCUDDER, Freehold, May 10, 1733—Oct. 16, 1781. Congressman. Killed in Revolution.
5. 1771—ISAAC SMITH, Trenton, 1740—Aug. 29, 1807. Congressman, Judge, Financier.
6. 1772—JAMES NEWELL, Freehold, 1725—Feb. 21, 1791. M.D. received in Edinburgh.
7. 1773—ABSALOM BAINBRIDGE, Lawrenceville, 1742—Jan. 23, 1807. A loyalist. Large practice in New York City. Father of Commodore Bainbridge.
8. 1774—THOMAS WIGGINS, Princeton, 1731—Nov. 14, 1801. Treasurer of College. Founder.
9. 1775—HEZEKIAH STITES, Cranbury, 1726—Nov. 17, 1790.

No meetings 1776-1780 on account of the War of the Revolution.

10. 1781—JAMES NEWELL, No. 6, reelected. Son Elisha President, 1795.
11. 1782—JOHN BEATTY, Trenton, Dec. 19, 1749—May 30, 1826. Commissary of prisoners in Revolution.
12. 1783—THOMAS BARBER, Matawan, died 1807, aged about 80. Surgeon in Revolution.
13. 1784—LAWRENCE VANDER VEER, Roycefield, 1740—1815. Last surviving founder of State Society.
14. 1785—MOSES BLOOMFIELD, Woodbridge, Dec. 4, 1729—Aug. 14, 1791. Surgeon in Revolution. Founder.
15. 1786—WILLIAM BURNET, Newark. President No. 2 in 1767.
16. 1787—JONATHAN ELMER, Bridgeton, Nov. 29, 1745—Sept. 30, 1817. U. S. Senator and Judge. In first class to receive M.D. degree from U. Pa.
17. 1788—JAMES STRATTON, Swedesboro, Aug. 20, 1755—Mar. 29, 1812. Judge.
18. 1789—MOSES SCOTT, New Brunswick, 1738—Dec. 28, 1781. Director of hospitals in Revolution.
19. 1790—JOHN GRIFFITH, Rahway, Nov. 19, 1736—Aug. 23, 1805. Founder. (Data requested.)
20. 1791—LEWIS DUNHAM, New Brunswick, 1754—Aug. 26, 1821. Revolutionary soldier.
21. 1792—ISAAC HARRIS, Middlesex County, and then Salem, 1741-1808. Taught medical students. Founder.
22. 1795—ELISHA NEWELL, Allentown, 1755—1799. Son of James, 6th President.

No meetings for twelve years, owing to an attempt to establish a rival society.

23. 1807—JONATHAN F. MORRIS, Somerville, Mar. 21, 1760—Apr. 10, 1810. Partner of 24th President.
24. 1808—PETER I. STRYKER, Somerville, June 22, 1766—Oct. 19, 1859. President three times.
25. 1809—LEWIS MORGAN, Rahway, 1757—Jan. 12, 1821.
26. 1810—LEWIS CONDUCT, Morristown, Mar. 3, 1773—May 26, 1862. Congressman. Trustee Princeton Coll.
27. 1811—CHARLES SMITH, New Brunswick, 1768—May 7, 1848. Poor boy, but died rich.
28. 1812—MATTHIAS H. WILLIAMSON, Elizabeth. Meager biography. Served two years.
29. 1814—SAMUEL FORMAN, Freehold, Aug. 3, 1764—Dec. 11, 1845. Active in practice.
30. 1815—JOHN VAN CLEVE, Princeton, 1778—Dec. 24, 1826. Lectured in medicine in Princeton College.
31. 1816—LEWIS DUNHAM, President No. 20 in 1791.
32. 1817—PETER I. STRYKER. See No. 24.
33. 1818—JOHN VAN CLEVE. See No. 30.
34. 1819—LEWIS CONDUCT. See No. 26.
35. 1820—JAMES LEE, Newark. No details. Large practice. Went to Baltimore.
36. 1821—WILLIAM G. REYNOLDS, Manalapan. A sailor. Had great mechanical skill.
37. 1822—AUGUSTUS R. TAYLOR, Somerville, May, 1782—1840. Very active.
38. 1823—WILLIAM B. EWING, Greenwich, Dec. 12, 1776—April 23, 1866. Member of Legislature. Judge.
39. 1824—PETER I. STRYKER. See Nos. 24 and 32.
40. 1825—GILBERT S. WOODHULL, Manalapan, Jan. 11, 1794—Oct. 13, 1830.

41. 1826—WILLIAM D. MCKISSACK, Millstone, 1754—Feb. 11, 1831. Son and father of leading doctors.
42. 1827—ISAAC PIERSON, Orange, Aug. 15, 1770—Sept. 22, 1833. Congressman and Sheriff. His son, No. 84, and his grandson, No. 115, were also Presidents.
43. 1828—JEPHTHA B. MUNN, Chatham, Dec. 24, 1780—June 22, 1863. Worked on Pharmacopoea.
44. 1829—JOHN W. CRAIG, Somerset Co. Meager record. (Data requested.)
45. 1830—AUGUSTUS R. TAYLOR. See No. 37.
46. 1831—THOMAS YARROW, Salem. Meager record. (Data requested.)
47. 1832—E. FITZ RANDOLPH SMITH, New Brunswick, 1786—May 25, 1865. Banker and Mayor.
48. 1833—WILLIAM FORMAN, Monmouth County, Aug. 7, 1796—Feb. 22, 1848. (Data requested.)
49. 1834—SAMUEL HAYES, Newark, 1776—July 30, 1839. Charged 25 cents a visit.
50. 1835—ABRAHAM P. HAGERMAN, Somerset County. Meager record. (Data requested.)
51. 1836—HENRY VANDERVEER, son of the 13th President, Somerville, 1792—Feb. 13, 1874. Very active.
52. 1837—LYNDON A. SMITH, Newark, May 11, 1795—Dec. 15, 1865. Promoted State Insane Asylum.
53. 1838—BENJAMIN H. STRATTON, Mt. Holly, Feb. 6, 1804—Dec. 31, 1875. Grandson of Dr. James Stratton, 17th President.
54. 1839—JABEZ G. GOBLE, Newark, Nov. 13, 1799—Feb. 7, 1857. "Handshaker", active. (Data requested.)
55. 1840—THOMAS P. STEWART, Hackettstown, 1800—Oct., 1846. (Data requested.)
56. 1841—FERDINAND S. SCHENCK, Six Mile Run, 1790—May 16, 1860. Congressman. Trustee Rutgers College.
57. 1842—ZACHARIAH READ, Mt. Holly, Sept. 19, 1802—July 28, 1879. A quiet, useful life.
58. 1843—ABRAHAM SKILLMAN, Bound Brook, Mar., 1796—Dec. 10, 1862. (More data requested.)
59. 1844—GEORGE R. CHETWOOD, Elizabeth, May 21, 1802—died aged over 80 years.
60. 1845—ROBERT S. SMITH, Bound Brook, Feb. 9, 1800—Aug. 25, 1874. A devoted physician.
61. 1846—CHARLES HANNAH, Salem. No obituary found. (Data requested.)
62. 1847—JACOB T. B. SKILLMAN, Woodbridge and New Brunswick, 1793—June 26, 1864. Student of Dr. A. R. Taylor, No. 37. Learned and judicious.
63. 1848—SAMUEL HAYES PENNINGTON, Newark, Oct. 16, 1806—Mar. 4, 1900. L.L.D. from Princeton.
64. 1849—JOSEPH FITHIAN, Woodbury, June 25, 1795—Jan. 8, 1881. "Courteous, of the old school."
65. 1850—ELIAS J. MARSH, Paterson, Jan. 7, 1803. Delegate to the first organization meeting of the A.M.A. on the first Wednesday of May, 1847.
66. 1851—JOHN H. PHILLIPS, Pennington, 1814—Mar. 1, 1878. Founder of State Normal School.
67. 1852—OTHNEIL H. TAYLOR, Camden, May 4, 1803—Sept. 6, 1869. Active in cholera epidemic.
68. 1853—SAMUEL LILLY, Lambertville, Oct. 15, 1815—Apr. 3, 1880. Congressman and Judge.
69. 1854—ALFRED B. DAYTON, Middletown Point, Dec. 25, 1812—July 19, 1870. Medical writer.
70. 1855—JAMES B. COLEMAN, Trenton, 1806—Dec. 19, 1877. Invented forced ventilation.
71. 1856—RICHARD M. COOPER, Camden, Aug. 30, 1806—May 24, 1874. Large practice.
72. 1857—THOMAS RYERSON, Newton, Feb. 18, 1821—May 27, 1887. Surgeon. Very active.
73. 1858—ISAAC PIERSON COLEMAN, Pemberton, Feb. 2, 1804—Nov. 4, 1869. Brother of No. 70.
74. 1859—JOHN R. SICKLER, Mantua, Sept. 20, 1800—Apr. 11, 1886. Judge.
75. 1860—WILLIAM ELMER, Bridgeton, Oct. 5, 1814—July 27, 1889. Third of four generations of doctors.
76. 1861—JOHN BLANE, Perryville, July 7, 1802—June 18, 1885. Wrote history of Hunterdon County Medical Society.
77. 1862—JOHN WOOLVERTON, Trenton, Oct. 27, 1825—Sept. 14, 1888. Mayor.
78. 1863—THEODORE R. VARICK, Jersey City, June 24, 1825—Nov. 23, 1887. Manager Morris Plains Hospital for Insane.
79. 1864—EZRA M. HUNT, Metuchen, Jan. 7, 1830—July 1, 1894. Established State Department of Health.
80. 1865—ABRAHAM COLES, Newark, Dec. 26, 1813—May 3, 1891. Poet, and active in practice.
81. 1866—BENJAMIN R. BATEMAN, Bridgeton, Mar. 7, 1807—July 23, 1883. Meager record. (Data requested.)
82. 1867—JOHN C. JOHNSON, Blairstown, Oct. 21, 1828—Dec. 23, 1907. Educator.
83. 1868—THOMAS J. CORSON, Trenton. Feb. 12, 1828—May 10, 1879. Superintendent of Schools.
84. 1869—WILLIAM PIERSON, Orange, Dec. 4, 1796—Oct. 1, 1882. Recording Secretary 1835-1866. Son of Isaac Pierson, No. 42.
85. 1870—THOMAS F. CULLEN, Camden, Sept. 3, 1823—Nov. 21, 1877. Writer.
86. 1871—CHARLES HASBROUCK, Hackensack, Apr. 11, 1818—Nov. 25, 1877. Civic leader.
87. 1872—FRANKLIN GAUNTT, Burlington, July 19, 1823—July 7, 1900. Supported early bacteriology.
88. 1873—THOMAS J. THOMASON, Perrineville, 1833—Aug. 2, 1880. Wrote History of Monmouth Co. Med. Soc.
89. 1874—GEORGE H. LARISON, Lambertville. Jan. 4, 1831—Mar. 7, 1892. Large practice. Local preacher.
90. 1875—WILLIAM O'GORMAN, Newark, July 12, 1824—Nov. 10, 1887. Founded St. Michael's Hospital.
91. 1876—JOHN V. SCHENCK, Camden, 1825—July 25, 1882. Obstetrician.
92. 1877—HENRY R. BALDWIN, New Brunswick, Sept. 18, 1829—Feb. 3, 1902. L.L.D. Rutgers, 1893.
93. 1878—JOHN S. COOK, Hackettstown, Jan. 19, 1823—Jan. 1, 1900. A family of country doctors.
94. 1879—ALEXANDER W. ROGERS, Paterson, 1814—May 14, 1905. Delegate to International Congress.
95. 1880—ALEXANDER N. DOUGHERTY, Newark, Jan. 1, 1822—Nov. 28, 1882. Controlled scurvy in Army of the Potomac.
96. 1881—LEWIS W. OAKLEY, Elizabeth, Nov. 22, 1828—Mar. 3, 1888. Three years in Civil War.
97. 1882—JOHN W. SNOWDEN, Blackwood, Apr. 22, 1823—May 28, 1888. Obstetrician.
98. 1883—STEPHEN SNOWES, Orange, Mar. 17, 1813—July 8, 1889. The great historian of The Medical Society of New Jersey, and leader of its organization and evolution.
99. 1884—PHANETT C. BARKER, Morristown. Living in 1903. No obituary found. (Data requested.)
100. 1885—JOSEPH PARRISH, Burlington, Nov. 11, 1818—Jan. 15, 1891. Established N. J. Reporter, Oct., 1847. Established training school for idiots. Member U. S. Sanitary Commission.

101. 1886—CHARLES J. KIPP, Newark, Oct. 22, 1838—Jan. 13, 1911. Founder Newark Eye and Ear Infirmary 1880.
102. 1887—JOHN W. WARD, Trenton, Feb. 12, 1860—Aug. 24, 1916. Supt. State Hospital, Trenton.
103. 1888—H. GENET TAYLOR, Camden, Feb. 12, 1860—Aug. 24, 1916. First proposed State Medical Journal. Son of No. 67.
104. 1889—BERIAH A. WATSON, Jersey City, 1836-1892. Civil War Veteran. Writer.
105. 1890—JAMES S. GREEN, Elizabeth, July 22, 1829—July 2, 1892. Father of No. 141.
106. 1891—ELIAS J. MARSH, JR., Paterson, Aug. 4, 1835—Aug. 3, 1908. Army Surgeon. Medical Director Mutual Life Ins. Co. Son of No. 65.
107. 1892—GEORGE T. WELCH, Passaic, 1845—Aug. 25, 1934.
108. 1893—JOHN G. RYERSON, Boonton, 1834—Feb. 10, 1916. Popular and practical.
109. 1894—OBADIAH H. SPRUL, Flemington, May 29, 1804—Feb. 13, 1925. Attended every State Society meeting during his medical lifetime.
110. 1895—WILLIAM ELMER, Trenton, Dec. 14, 1840—July 18, 1908. See No. 16.
111. 1896—THOMAS J. SMITH, Bridgeton, 1841—June 14, 1932. Established Epileptic Colony at Skillman.
112. 1897—DAVID C. ENGLISH, New Brunswick, Mar. 2, 1842—Sept. 19, 1924. Editor of Journal and Trustee.
113. 1898—CLAUDIUS R. P. FISHER, Bound Brook, Aug. 12, 1859—June 5, 1927. Civic affairs.
114. 1899—LUTHER M. HALSEY, Williamstown, Sept. 17, 1858—March 20, 1921. Legislative Committee.
115. 1900—WILLIAM PIERSON, JR., Orange, Nov. 20, 1830—June 12, 1900. Secretary 31 years as was his father, William, No. 83, Secretary 1866-1897.
116. 1901—JOHN D. MCGILL, Jersey City, 1846-1912. Surgeon General of N. J. Banker.
117. 1902—EDWARD L. B. GODFREY, Camden, Feb. 21, 1850—Dec. 17, 1913. Wrote "Medical History of Camden County". A born leader.
118. 1903—HENRY MITCHELL, Asbury Park, Aug. 6, 1845—Jan. 31, 1919. Public health and State Department of Health.
119. 1904—WALTER B. JOHNSON, Paterson, Jan. 3, 1852—1922. Eye and ear specialist.
120. 1905—HENRY W. ELMER, Bridgeton, Apr. 26, 1847—Feb. 13, 1907. Active in civic duties.
121. 1906—ALEXANDER MARCY, JR., Riverton, 1860—May 1, 1934.
122. 1907—EDWARD J. ILL, Newark. Born 1854. Senior Fellow.
123. 1908—DAVID ST. JOHN, Hackensack, Mar., 1850—Sept. 14, 1917. "A doctor of the old school."
124. 1909—BENJAMIN A. WADDINGTON, Salem. Died Aug. 23, 1917, aged 75 years.
125. 1910—THOMAS H. MACKENZIE, Trenton, Mar. 14, 1847—Dec. 19, 1920. Surgeon.
126. 1911—DAVID STROCK, Camden, 1842—June 10, 1927. Sanitarian, Church Organist.
127. 1912—NORTON L. WILSON, Elizabeth, 1861—Nov. 13, 1930. "Quiet wisdom."
128. 1913—ENOCH HOLLINGSHEAD, Pemberton, 1853—Feb. 13, 1934. Treasurer, Burlington County Medical Society 34 years.
129. 1914—FRANK D. GRAY, Jersey City, 1857—June 11, 1916. Active and original.
130. 1915—WILLIAM J. CHANDLER, South Orange, July 11, 1842—Oct. 30, 1927. Secretary 15 years. Chairman, Publication Committee. Organist.
131. 1916—PHILIP MARVEL, 1856—Sept. 6, 1938. Active and prominent.
132. 1917—WILLIAM G. SCHAUFFLER, Lakewood, Oct. 28, 1862—Apr. 30, 1933. President, New Jersey Health and Sanitary Association.
133. 1918—THOMAS W. HARVEY, Orange, 1853—Apr. 8, 1938. Active on Welfare Committee.
134. 1919—GORDON K. DICKINSON, Jersey City, Dec. 14, 1855—June 25, 1930. Leader in tuberculosis work.
135. 1920—PHILANDER A. HARRIS, Paterson, Jan. 29, 1852—Dec. 13, 1924. Gynecologist and author, and Health Commissioner.
136. 1921—HENRY B. COSTILL, Trenton, 1860—Apr. 27, 1935. Medical legislation and public health.
137. 1922—JAMES HUNTER, JR., Westville, Jan. 14 1866—June 1, 1931. Active in State Society.
138. 1923—WELLS P. EAGLETON, Newark. Born 1865.
139. 1924—ARCHIBALD MERCER, Newark, 1849—Nov. 3, 1931. Assistant Director, Mutual Life Ins. Co. of N. J.
140. 1925—LUCIUS DONOHUE, Bayonne. Born 1868.
141. 1926—JAMES S. GREEN, Elizabeth, 1864—June 20, 1936. "A practical idealist." Son of No. 105.
142. 1927—WALT P. CONAWAY, Atlantic City. Born 1873.
143. 1928—EPHRAIM R. MULFORD, Burlington, born Oct. 17, 1880—March 10, 1939. Active in civic medicine.
144. 1929—ANDREW F. MCBRIDE, Paterson. Born 1865.
145. 1930—GEORGE N. J. SOMMER, Trenton. Born 1874.
146. 1931—JOHN F. HAGERTY, Newark, May 9, 1869—Feb. 1, 1937. Surgeon, scholar, church worker, musician.
147. 1932—A. HAINES LIPPINCOTT, Camden, July 12, 1867—Mar. 10, 1937. Urologist, Cooper Hospital.
148. 1933—FREDERIC J. QUIGLEY, Union City. Born 1883.
149. 1934—LANCELOT ELY, Somerville. Born 1875.
150. 1935—MARCUS W. NEWCOMB, Brown's Mills. Born 1880.
151. 1936—FRANCIS R. HAUSSLING, Newark. Born 1880. Resigned because of ill health.
152. 1936—SPENCER T. SNEDECOR, Hackensack. Born 1900.
153. 1937—WILLIAM G. HERRMAN, Asbury Park. Born 1890.
154. 1938—WILLIAM J. CARRINGTON, Atlantic City. Born 1884.

The names of living Fellows are in bold face type.

The available records of a number of Fellows is meager, and more information is requested.

HONORARY MEMBERS

Those marked with an asterisk are deceased

*David Hosack, New York	1827	*D. Hayes Agnew, Philadelphia	1886
*John W. Francis, New York	1827	*Joseph Leidy, Philadelphia	1886
*John Condict, Orange	1830	*Frederick S. Dennis, New York	1893
*Usher Parsons, Rhode Island	1839	*John H. Ripley, New York	1893
*Reuben D. Murphy, Cincinnati	1839	*Virgil P. Gibney, New York	1893
*Alban G. Smith, New York	1839	*William Pierson, Orange, N. J.	1894
*Willard Parker, New York	1842	*Abraham Jacobi, New York	1896
*Valentine Mott, New York	1843	*Virgil M. D. Marcy, Cape May City	1896
*Johnathan Knight, New Haven	1848	*Samuel H. Pennington, Newark, N. J.	1897
*National Chapman, Philadelphia	1848	*Alfred A. Woodhull, Princeton, N. J.	1897
*John H. Stephens, New York	1848	*J. Leonard Corning, New York	1902
*John C. Warren, Boston	1849	*John Allen Wyeth, New York	1903
*Lewis C. Beck, New York	1850	*William K. Van Reypen, U. S. N.	1903
*John C. Torrey, New York	1850	*Lawrence F. Flick, Philadelphia	1903
*George B. Wood, Philadelphia	1853	S. Adolphus Knopf, New York	1906
*Horace A. Buttolph, Short Hills, N. J.	1854	*Albert Vander Veer, Albany, N. Y.	1907
*Ashbel Woodward, Franklin, Conn.	1861	Charles K. Mills, Philadelphia	1917
*Thomas W. Blatchford, Troy, N. Y.	1866	Richard C. Cabot, Boston	1917
*Jeremiah S. English, Menalapan, N. J.	1867	George W. Crile, Cleveland, Ohio	1917
*Stephen Wickes, Orange, N. J.	1868	*John B. Deaver, Philadelphia	1917
*Samuel Oakley Vanderpool, Albany, N. Y.	1872	*William J. Chandler, Lawtey, Florida	1923
*Joseph Parrish, Burlington, N. J.	1872	Edward J. Ill, Newark, N. J.	1925
*Ferris Jacobs, Delhi, N. Y.	1872	Joseph E. Raycroft, Princeton, N. J.	1930
*Charles A. Lindsley, New Haven, Conn.	1872	Jackson B. Pellett, Hamburg, N. J.	1933
*William Pepper, Philadelphia	1876	Wells P. Eagleton, Newark, N. J.	1935
*S. Weir Mitchell, Philadelphia	1876	*Vanderhoef M. Disbrow, Lakewood, N. J.	1935
*Cyrus F. Brackett, Princeton, N. J.	1880	*Philip Marvel, Bethlehem, Pa.	1935
*Joseph C. Hutchinson, Brooklyn, N. Y.	1880	Joseph B. Harrison, Westfield, N. J.	1936
*Thomas Addis Emmett, New York	1884	*Thomas W. Harvey, Orange, N. J.	1936
*Isaac E. Taylor, New York	1884	Andrew F. McBride, Paterson, N. J.	1936

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

EXECUTIVE AND EDITORIAL OFFICES, 143 EAST STATE ST., TRENTON, N. J.
TELEPHONE TRENTON 9330

"THIS SOCIETY SHALL BE COMPOSED OF FELLOWS, OFFICERS, DELEGATES, AND MEMBERS OF COMPONENT SOCIETIES IN GOOD STANDING." CONSTITUTION, ARTICLE IV, SEC. 1.

OFFICERS

An up-to-date list of the officers and committeemen of The Medical Society of New Jersey, and of the President, Secretary, and Reporter of each component county society, is printed in each issue of The Journal.

DELEGATES

Representatives from the component county societies to the House of Delegates are elected by each County Society from among its members who are in good standing. The names of the elected delegates will be printed in the official Program of the Annual Meeting.

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

THE MEDICAL SOCIETY OF NEW JERSEY

ON MARCH 15, 1939

An asterisk (*) indicates a deceased member

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in May.

Active Members

Allman, David B., 104 St. Charles pl., Atlantic City
Andrews, Clarence L., 1616 Pacific av., Atlantic City
Barbash, Samuel, 1902 Pacific av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., 1616 Pacific av., Atlantic City
Beir, Ily R., 114 S. Virginia av., Atlantic City
Bossert, Charles L., 4021 Atlantic av., Atlantic City
Boysen, Theophilus H., 100 Phila. st., Egg H'rbr'r C'y
Bradley, Robt. A., 1616 Pacific av., Atlantic City
Brown, J. Carlisle, 101 S. Indiana av., Atlantic City
Carrington, Wm. J., 905 Pacific av., Atlantic City
Chalfant, W. Paxson, Jr., 7003 Ventnor av., Ventnor
Charlton, C. Coulter, 124 S. Illinois av., Atlantic C'y
Chew, Elisha C., 603 Pacific av., Atlantic City
Clark, S. Worth, 152 S. No. Carolina av., Atlantic C'y
Cleary, Jos. P., Minotola
Conaway, Walt P., 1723 Pacific av., Atlantic City
Corson, Filbert R., 101 S. Indiana av., Atlantic City
Crane, Bernard, 306 Pacific av., Atlantic City
Dalton, S. Eugene, 117 S. Illinois av., Atlantic City
Davidson, Harold S., 101 S. Indiana av., Atlantic C'y
Davis, W. Cole, 109 S. Portland av., Ventnor
deHellebranth, Roland T., 104 S. Fr'nkft' av., Ventn'r
Di Nicolantonio, Vincent J., 1902 Pacific av., Atl.C'y
Diskan, Samuel M., 1904 Pacific av., Atlantic City
Durham, Royal E., 130 S. Illinois av., Atlantic City
Dyer, Edward H., 102 S. Victoria av., Ventnor
Eckert, Walter L., 4430 Chestnut st., Phila., Pa.
Elliott, Frazier J., 10 N. Second st., Hammonton
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Feinstein, Louis, 410 Pacific av., Atlantic City
Fish, Clyde M., 7 W. Washington av., Pleasantville
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtille, 227 Philadelphia av., Egg Harbor C'y
Gorson, Samuel F., 2005 Pacific av., Atlantic City
Grier, Robt. M., 50 E. Washington av., Pleasantville
Gruhler, Jean A., 5407 Atlantic av., Ventnor
Guion, Edward, Atl. Co. Hosp. for Ment'l Dis., Northf'd
Halpern, Samuel, 504 Pacific av., Atlantic City
Harley, Halvor L., 101 S. Indiana av., Atlantic City
Harris, Wm. O., 812 Arctic av., Atlantic City
Henderson, Kenneth P., 121 S. Illinois av., Atl. City
Hersohn, Wm. W., 116 S. Illinois av., Atlantic City
Hess, L. Elmore, 19 E. Bolton av., Absecon
Hoffman, Harry S., 3302 Pacific av., Atlantic City
Holmes, H. David, 1813 Arctic av., Atlantic City
Holoman, M. Browne, 1 N. Haverford av., Margate
Holt, Edward Z., 4100 Atlantic av., Atlantic City
Hudson, Howard S., 34 E. Main st., Mays Landing
Hudson, Woodburn J., 123 W. Wash. av., Pl's'ntville
Hyman, Chas., 2619 Pacific av., Atlantic City
Infield, G. L., 1401 Shore rd., Northfield
Irvin, John S., 1910 Pacific av., Atlantic City
Jacobson, John J., 1616 Pacific av., Atlantic City
Johnson, V. Earl, 101 S. Indiana av., Atlantic City

Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 905 Pacific av., Atlantic City
Kilduffe, Robert A., Atlantic City Hosp., Atlantic C'y
Kline, Herman, 2643 Pacific av., Atlantic City
Krechmer, Abraham, 521 Pacific av., Atlantic City
Lawther, B. M., 1401 Shore rd., Northfield
Leonard, Isaac E., 2342 Atlantic av., Atlantic City
Madden, Leland S., 21 E. Verona av., Pleasantville
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., 4212 Ventnor av., Atlantic City
Marshall, H. Donald, 611 N. Indiana av., Atlantic C'y
Marshall, Jos. C., 1517 Pacific av., Atlantic City
Mason, James H., 1616 Pacific av., Atlantic City
McGeehan, Stanley M., Ryanhurst Apt., Atlantic C'y
Merendino, Anthony G., 2720 Pacific av., Atl. City
MeVay, James C., 2907 Pacific av., Atlantic City
Molitch, Matthew, 705 Pacific av., Atlantic City
Murray, Clifford K., 7103 Ventnor av., Ventnor
Nickman, E. Harrison, 101 S. Newton av., Atl. City
Pennington, John, 101 S. Indiana av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., Atlantic City
Poland, Geo. A., 206 E. Verona av., Pleasantville
Quinn, Norman J., 3303 Pacific av., Atlantic City
Read, Hilton S., 5407 Atlantic av., Ventnor
Reyner, Daniel C., 2703 Pacific av., Atlantic City
Rieck, Allan, 507 S. Shore rd., Pleasantville
Roop, William O., 101 S. Indiana av., Atlantic City
Rosenberg, Louis, 26 S. Stenton pl., Atlantic City
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
Salasin, Samuel L., 511 Pacific av., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, Geo. C., 2901 Pacific av., Atlantic City
Schwinn, Chas., 7600 Winchester av., Margate City
Scott, J. Hurlong, 121 N. Virginia av., Atlantic City
Scott, Karl McC., 1616 Pacific av., Atlantic City
Shavelson, Irving C., 3322 Ventnor av., Atlantic City
Shenfeld, Isaac, 4806 Atlantic av., Ventnor
Shimer, A. Burton, 606 Pacific av., Atlantic City
Shivers, Chas. H. deT., 121 S. Illinois av., Atlantic C'y
Shore, Ernest L., 306 Atlantic av., Atlantic City
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Singley, Harry P., Jr., 101 S. Buffalo av., Ventnor
Sinkinson, Chas. D., Jr., 1616 Pacific av., Atlantic C'y
Smith, Andrew M., 344 Phil'd'lphia av., Egg H'rbr'r C'y
Stalberg, Isaac Z., 1616 Pacific av., Atlantic City
Stamps, G. Ruffin, 300 E. Verona av., Pleasantville
Stern, Samuel, 2315 Pacific av., Atlantic City
Stevenson, Alexander M., 7506 V'ntn'r av., M'rg'te C'y
Stewart, Sloan G., 16 N. Jackson av., Ventnor
Stewart, Walter B., 8 N. Tallahassee av., Atlantic C'y
Subin, Harry, 1616 Pacific av., Atlantic City
Surran, Carl A., 1616 Pacific av., Atlantic City
Timberlake, Baxter H., 1616 Pacific av., Atlantic C'y
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Walker, Levi M., 110 S. No. Carolina av., Atl. City
Weiner, Samuel E., 904 Pacific av., Atlantic City

Westney, Alfred W., 3005 Pacific av., Atlantic City
Whims, Clarence B., 5401 Ventnor av., Ventnor
White, R. Rostin, 644 Shore rd., Somers Point
Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., 1616 Pacific av., Atlantic City

Associate Member

Rechtman, A. M., 1217 Pacific av., Atlantic City

Courtesy Members

Barab, B.B., D.D.S., 1616 Pacific av., Atlantic City
Mally, Manuel J., D.D.S., 1900 Pacific av., Atl. City
Philips, Chas. F., D.D.S., 1509 Pacific av., Atl. City
Steigerwald, Clarence S., D.D.S., 4711 Atl. av., Atl. City

von Deilen, Arthur W., D.D.S., 2703 Pacific av., Atl. City
Whitehill, Norman J., D.D.S., 1904 Pacific av., Atl. City

Honorary Members

Brown, Mr. Elmer E.
Ireland, Milton S., 23 S. California av., Atlantic City
Marcus, Joseph H., 4702 Atlantic av., Atlantic City
Miller, Daniel J. M., 104 S. Jackson av., Ventnor

Transferred

Molitch, Matthew, from Philadelphia, Pa.

Number of Active Members and basis of representation, 116, March 15, 1939.

BERGEN COUNTY (2)

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

Active Members

Anderson, Reuben M., 408 Main st., Hackensack
Appold, George D., 60 E. Church st., Bergenfield
Bakel, H. Sheridan, 155 Van Wagenen av., Jer. City
Balze, Henry R., 147 Christie st., Leonia
Barlow, G. Barton, 157 Engle st., Englewood
Barnes, Wm. J., 155 Engle st., Englewood
Berke, Raynold N., 430 Union st., Hackensack
Bernard, Richard C., 248 State st., Hackensack
Blake, Roger N., 729 Kinderkamack rd., River Edge
Blauvelt, Grace B., 76 Heights rd., Ridgewood
Bleasby, Charles B., 136 Passaic st., Garfield
Blenkle, Victor A., 140 Chadwick rd., Teaneck
Bono, Jos. J., Paris av., Northvale
Bookstaver, Barnet S., 193 Norma rd., Teaneck
Bregman, Alexander, 2 Dempsey av., Edgewater
Brown, John L., 647 Anderson av., Grantwood
Buckley, Paul J., 159 Palisade av., Bogota
Burnham, Lyman, 229 Engle st., Englewood
Burns, Geoffrey C. H., County rd & So. st., Demarest
Busicco, Philip S., 131 Liberty rd., Englewood
Byers, Clarence W., 176 Union av., Rutherford
Caldrony, Thos. L., 66 Bergen av., Ridgewood Park
Campbell, James M., 101 S. Central av., Ramsey
Candio, Vincent P., 347 Ridge rd., Lyndhurst
Cartnick, Louis C., 228 Hillcrest av., Wood Ridge
Chase, Kalman, 591 N. Maple av., Hohokus
Clarie, D'Arcy C., 558 Broad av., Ridgewood
Clarke, Edward W., 435 Warwick av., W. Englewood
Cloud, Albert W., Hugenot av., Englewood
Cochrane, Cleland D., Main st., Closter
Connor, Clarence A., 1586 Center av., Fort Lee
Cooke, H. Hamilton, 100 Prospect st., Ridgewood
Cooper, Howard M., 37 Ridge rd., Rutherford
Coppoletta, Jos. M., 452 Palisade av., Cliffside Park
Craig, William C., 235 E. Ridgewood av., Ridgewood
Crandall, John K., 200 Main st., Fort Lee
Cropsey, Chas. D., 168 Chestnut st., Rutherford
Curtis, Donald A., 241 Union st., Hackensack
D'Agostin, Henry, 243 Fulton ter., Cliffside
DeBiao, Cornelius V., 9 W. Park pl., Rutherford
Demarest, J. Willis, 124 Elm av., Hackensack
DeSanto, Anthony M., 377 Essex st., Hackensack
Dezer, Chas. N., Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Frederick G., 210 Main st., Hackensack
Edwards, J. Bennett, 144 Wood Ridge pl., Leonia
Ellmers, B. J., New Milford av., New Milford
Essertier, Edward P., 273 State st., Hackensack
Farr, Walter J., 288 Griggs av., Teaneck
Fermaglich, H. B., 881 Garrison av., Teaneck
Ferrari, Andrew F., 110 Hackensack st., E. Rutherford

Finke, George W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
Fisher, Percy C., 145 Franklin av., Ridgewood
Fitzhugh, Wm. F., 190 Euclid av., Ridgewood Park
FitzPatrick, Leo J., 134 Bergen av., Ridgewood Park
Forte, F. Chester, 65 Hudson st., Hackensack
Franklin, Sidney I., 163 Washington av., Fort Lee
Freeland, Frank, 231 State st., Hackensack
Friedman, Abraham I., 230 State st., Hackensack
Garrett, Harry S., 15 Park av., Park Ridge
Gershman, Jos. G., 99 W. Madison av., Dumont
Gilady, Raphael, 205 Union st., Hackensack
Gittelsohn, Isador, 896 Kinderkamack rd., River Edge
Goldberg, David, 7 Bogert pl., Westwood
Goldfarb, Abraham, 52 Chestnut st., Rutherford
Gordon, Joseph, Bergen Pines, Oradell
Gramsch, A. Louis, Bergen Pines, Oradell
Greenfield, Arthur W., 50 Anderson st., Hackensack
Greenfield, Wm. J., 50 Anderson st., Hackensack
Groff, Parker A., 159 Washington av., Little Ferry
Hallett, Frederick S., 200 Passaic st., Hackensack
Halpern, Herman, 143 Engle st., Englewood
Hawes, Vernon L., 63 Church st., Ramsey
Helff, Joseph R., 1367 Teaneck rd., W. Englewood
Heller, Geo., 100 E. Palisade av., Englewood
Hitzemann, Louis A., 30 E. Passaic st., Maywood
Hoheb, Albert S., 5 Lincoln av., Rutherford
Horowitz, Herman J., 872 Broad av., Ridgewood
Huff, Edmund N., 1635 Bedford rd., San Marino, Cal.
Hull, Donald B., 7 W. Ridgewood av., Ridgewood
Irwin, John H., 51 Tenafly rd., Englewood
Jenkins, Alvah R., 40 Amory st., Englewood
Johnson, G. Leonard, 390 Booth av., Englewood
Johnston, Sidney F., 365 Rochelle av., Rochelle Park
Jordan, Walter L., 146 Engle st., Englewood
Jukofsky, Isidore D., 32 Union pl., Ridgewood Park
Kakascik, Emil J., 206 Palisade av., Garfield
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kennedy, Paul A., 147 Tenafly rd., Englewood
King, Chester A., 412 Kinderkamack rd., Oradell
Kissinger, Donald J., 120 E. Madison av., Dumont
Knapp, Richard E., 25 Hudson st., Hackensack
Knight, Wm. T., 515 Oradell av., Oradell
Knowles, Geo. M., 241 Main st., Hackensack
Knox, Harriet L., 390 Union st., Hackensack
Kraissl, Cornelius J., 393 Main st., Hackensack
Legato, Samuel F., 417 Palisade av., Cliffside Park
Lesko, Stephen W., 234 Mt. Pleasant av., Wallington
Levitas, Irving M., 388 Kinderkamack rd., Westwood
Lewis, Alice B., E. Saddle River rd., Saddle River
Littwin, Chas., 962 Queen Anne rd., Teaneck

Liva, Arcangelo, 5 Pangborn pl., Hackensack
Loman, Sam'l G., Magn'lia & Jef'rs'n av., Cresskill
Lueddecke, Roland E., 216 Randolph av., E. R'th'rf'd
Luria, Sanford A., Bergen Pines, Oradell
Lynch, Maurice M., 396 Union st., Hackensack
Lyons, Romola L. K., 171 Meadowbr'k rd., Englew'd
Macaulay, Francis A., 815 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenafly
Mader, Anthony L., Jr., 430 Union st., Hackensack
Markley, Luther A., Holy Name Hosp., Teaneck
McCormack, Frank C., 95 Tenafly rd., Englewood
McDannald, William S., 41 Magnolia av., Tenafly
McLane, A. Donald, 498 Engle st., Englewood
McLeod, Harry J., 71 Forest rd., Tenafly
Mears, Wm. G., 222 Overlook av., Leonia
Metz, Henry, 5 Pangborn pl., Hackensack
Meyer, Howard M., 400 Maple Hill dr., Hackensack
Mockett, Walter W., 714 Palisade av., Grantwood
Morrow, Joseph R., Bergen Co. Hosp., Ridgewood
Mosher, Henry L., 325 Valley Brook av., Lyndhurst
Muller, Fred'k L., 413 3rd st., Carlstadt
Mulligan, Luke A., 230 Central av., Leonia
Myers, Norman V., 301 Knickerbocker rd., Tenafly
Netz, Lester W., 414 Main st., Hackensack
Nichols, Frank I., 52 Euclid av., Hackensack
Nicol, Lorenz C., 360 Larch av., Bogota
O'Brien, Paul, 196 Main st., E. Rutherford
Olpp, John L., 100 E. Palisade av., Englewood
Oren, Hyman, Park av., Park Ridge
Pagano, Peter, 45 N. Broad st., Ridgewood
Patti, Frank A., 304 Broad av., Leonia
Payne, Joseph, 223 Godwin av., Midland Park
Pedevill, Joseph R., 232 Highland av., Palisades P'k
Perham, Roy G., 248 Boulevard, Hasbrouck Heights
Pettit, Harry H., 138 Franklin av., Ridgewood
Phillips, Walter, 109 E. Palisade av., Englewood
Pierce, H. A., 150 Broad av., Leonia
Pitkin, Geo. P., 4 S. Washington av., Bergenfield
Policastro, Nelson C., 378 Union st., Hackensack
Prall, Henry E., 755 Anderson av., Cliffside Park
Prather, Charles G., 260 Westwood av., Westwood
Prather, John W., 155 Washington av., Dumont
Prout, Wm. B., 88 W. Forrest av., W. Englewood
Rader-Hoheb, Katherine A., 5 Lincoln av., Rutherford
Reich, Samuel B., 348 Kinderkamack rd., Oradell
Reid, Erwin W., 125 Marsellus pl., Garfield
Reinhold, H. E., 441 W. Englewood av., W. Englew'd
Richardson, Chas. A., Main st., Closter
Richter, Donald A., 185 Grand av., Englewood
Robinson, S. E., Franklin Turnpike, Waldwick
Rube, Jos. A., 145 Prospect st., Ridgewood
Ruch, Louis, 129 Engle st., Englewood
Ruch, Valentine, 115 W. Palisade av., Englewood
Rucker, William C., 408 Main st., Hackensack
Sandler, Moses, 1630 Center av., Fort Lee
Sandler, Sam'l A., Hospital pl. & Atl'ntic st., H'ck'ns'k
Sarla, Michael, 55 Hudson st., Hackensack
Schmidt, Walter W., 386 Palisade av., Cliffside Park
Scullion, Arthur A., 460 Anderson av., Cliffside P'k
Sealey, Henry J., 79 Washington av., Dumont
Segard, Christian P., 204 Glenwood av., Leonia
Seiler, Benjamin, 330 Palisade av., Cliffside Park
Sexton, Edward V., 936 Queen Anne rd., Teaneck
Seymour, Edward T., 55 Hillside av., Tenafly
Skvarla, John A., 17 Koster st., Wallington

Smaine, Enrique delC., 502 Summit av., Carlstadt
Smith, Nehemiah E., 33½ Humphrey st., Englew'd
Snedecor, Spencer T., 50 Anderson st., Hackensack
Solworth, Lee, 100 E. Palisade av., Englewood
Tennis, Edgar M., 240 Engle st., Englewood
Tether, Russell K., Main st., Closter
Tidwell, Geo. W., 17 Union Blvd., Wallington
Toal, Joseph, 803 Prospect av., Ridgefield
Tomlins, Francis I., 102 Walnut st., Ridgewood
Trossbach, Herman, 97 Palisade av., Bogota
Tyson, Frances B., 101 Leonia av., Leonia
Vanderbeek, Stuart W., 143 Engle st., Englewood
Van Dyke, Joseph S., 42 Palisade Blvd., Palisades P'k
Vita, Frank J., 595 Palisade av., Grantwood
Vroom, Wm. L., 7 W. Ridgewood av., Ridgewood
Walsh, Thomas M., 210 Kipp av., Hasbrouck Hgts.
Ward, Alfred W., County rd., Demarest
Ward, G. Harold, 240 Engle st., Englewood
Warren, Charles B., 181 Prospect av., Bergenfield
Webb, Wilson D., 316 State st., Hackensack
White, Frank S., 916 Red rd., Teaneck
Whitman, Lloyd B., 7 West Clinton av., Bergenfield
Whittaker, Neil McL., 418 Main st., Hackensack
Widetsky, Alfred, 85 Broadway, E. Paterson
Williams, William C., 9 Ridge rd., Rutherford
Willis, Benedict P., 23 Park av., Rutherford
Wilson, Harrison B., 490 Union st., Hackensack
Winter, Gladys C., 717 Norma ct., Teaneck
Witkoff, Ben, 215 Terrace av., Hasbrouck Heights
Wolowitz, Harry B., 20 Spring Valley rd., Hackens'k
Worcester, George F., 220 Engle st., Englewood
Wry, Orlin V., 95 High st., E. Rutherford
York, James L., 331 River rd., New Milford

Junior Members

Andrick, Eugene A., Hohokus
Banta, Raymond E., 118 E. Clinton av., Tenafly
Brown, Leonard, Hackensack Hospital, Hackensack
Carbone, Ralph, Hackensack
Coughlin, Joseph J., Ridgefield Park
Grueninger, Edward F., 24 Columbia av., Grantw'd
Hensle, Otto S., 428 First st., Carlstadt
Lemmerz, Willard H., 164 Mortimer av., Rutherford
Levy, Jack D., 801 N. Wood av., Linden
Lord, C. Donald, 496 S. Maple av., Glenrock
Marx, Fred'k J., 281 W. Englew'd av., W. Englew'd
Neary, Edward R., Palisades Park
Placa, James A., 11 Ethelbert pl., Ridgewood
Ringe, Charles L., Jr., Palisade av., Teaneck
Ringewald, Robt. H., 133 New York av., Jersey City
Schretzmann, Rudolph C., 597 Riverside av., R'th'rf'd
Spicola, Louis A., 549 Anderson av., Wood Ridge
Weigle, Carl E., 25 Gifford av., Jersey City

Transferred

Cooke, H. H., from Florida
Dahlquist, R. M., to Winneshiek County, Iowa
Gramsch, A. L., from Hunterdon Co. Medical Soc.
Olpp, J. L., from Kings County Medical Society, N.Y.
Sandler, S. A., from Hudson County Medical Society

Number of Active Members and basis of representation, 201, March 15, 1939.

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Meets second Thursday evening of each month, except June, July and August. Annual Meeting in May.

Active Members

Anderson, Richard D., 465 High st., Burlington
Betts, R. Winfield, 22 N. Main st., Medford
Bray, Wm. E., 41 Elizabeth st., Pemberton
Busansky, Samuel T., Circle dr., Browns Mills
Conroy, John S., 122 E. Broad st., Burlington
Curtis, Howard C., 129 Chester av., Moorestown
Darlington, Emlen P., New Lisbon
Davis, E. Vernon, Vincentown
Davis, Jacob M., 1400 High st., Burlington
Dickson, T. Bruce, 408 Main st., Riverton
Downs, Roscius I., 40 Scott st., Riverside
Fahrenbruch, F. D., 101 Garden st., Mt. Holly
Geary, Russel D., Riverside
Haines, Edgar J., Medford
Haldeman, Robert E., Mt. Holly
Hartman, Luther M., 8 E. Main st., Maple Shade
Hollingshead, Lyman B., Pemberton
Hornberger, J. Howard, 5 Fifth av., Roebling
Hunter, Edward R., 321 Union av., Delanco
Imhoff, Robert E., 29 E. Main st., Moorestown
Kuder, Joseph M., 104 Garden st., Mt. Holly
Landis, Harry P., Jr., 925 Columbia av., Palmyra
Longsdorf, Harold E., Mt. Holly
Love, Elizabeth F., 142 E. Oak av., Moorestown
Lucas, Wm. F., 23 W. Broad st., Burlington
Mark, Harry B., Riverton
Mendenhall, Clinton D., 412 Farnsw'th av., B'rd'nt'n
Metzer, Emma P. W., 430 Fairview st., Riverside
Metzer, Freeman W., 428 Fairview st., Riverside
Mills, Charles S., 106 Lippincott av., Riverton
Muldoon, Edward J., 200 Third st., Florence

*Mulford, Ephraim R., 100 E. Broad st., Burlington
Munro, Chas. A., Marlton
Newcomb, Marcus W., Browns Mills
Peacock, Arthur B., 39 W. Main st., Columbus
Remer, Daniel F., 417 High st., Mt. Holly
Rodman, E. Warren, 503 Cooper st., Beverly
Rogers, Harry L., 408 Main st., Riverton
Schisler, Milton M., 2nd & Church sts., Florence
Scott, Parry M., 466 Cooper st., Beverly
Shapiro, Chas. S., Maple Shade
Shipps, Hammell P., 739 Chestnut st., Delanco
Small, E. Lester, 30 Branch st., Medford
Sparks, Paul R., 21 W. Broad st., Burlington
Stokes, Joseph, 220 E. Main st., Moorestown
Stokes, S. Emlen, 129 Chester av., Moorestown
Summey, Thomas J., 201 E. Oak av., Moorestown
Thorne, Nathan, 117 Chester av., Moorestown
Tracy, George T., 222 Warren st., Beverly
Ulmer, D. H. B., 199 Chestnut st., Moorestown
Viteri, Luis E., 13 Brainerd st., Mount Holly
Wagner, J. Geo., Riverbank, Delanco
Wyman, Edward H., 100 E. Broad st., Burlington

Honorary Member

Wilkinson, George H., Moorestown

Resigned

Gladden, Ralph G.

Number of Active Members and basis of representation, 53, March 15, 1939.

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June. Annual Meeting in May.

Active Members

Adams, Geo. B. McC., 304 Monmouth st., Gloucester
Anderson, Wm. M., 20 Kings Hgwy. W., Haddonf'd
Andrus, David L., 805 Cooper st., Camden
Asbell, Nathan, 328 Cooper st., Camden
Assante, Mario H., Evesham av., Magnolia
Athey, Kenneth L., 3616 Westfield av., Camden
Baker, Banks S., 601 Walnut st., Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
Barnshaw, Harold D., 406 Cooper st., Camden
Barroway, James N., 2626 Federal st., Camden
Becker, C. Fred, 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av., Merchantville
Bentley, David F., Jr., 406 Cooper st., Camden
Betancourt, Raul R., 406 Cooper st., Camden
Braun, William, 4307 W. Maple av., Merchantville
Brennan, Chas. L. S., 14 S. Broadway, Gloucester C'y
Brennan, John P., 429 Cooper st., Camden
Brown, Stanley L., Glen av. & Locust st., Laurel Sprgs.
Browning, W. Kempton, 120 N. Centre st., Merch'tv'le
Browning, Wm. J., 134 N. Centre st., Merchantville
Burns, Wilmer F., 267 White Horse Pk., Audubon
Bush, Ralph K., 131 E. Park av., Merchantville
Buzby, B. Franklin, 414 Cooper st., Camden
Carlander, O. R., 1972 Browning rd., Merchantville
Casselman, Arthur J., 301 N. 2nd st., Camden
Ciliberti, Frank J., Jr., 713 S. 5th st., Camden
Clark, Ernest W., 209 Haddon av., Westmont

Clement, Lavinia B., 124 Kings Hghwy. W., Haddonf'd
Cohen, Paul, 210 State st., Camden
Collier, Martin H., Camden Co. T.B. Hosp., Grenloch
Corpening, Flave Hart, Park av., Laurel Springs
Coxson, Harold P., Laurel rd., Stratford
Crist, Walter A., 725 Collings av., W. Collingswood
Crowley, Joseph Wright, 4005 Westfield av., Camden
Davis, Albert B., 511 Cooper st., Camden
Day, Grafton E., Frazer & N. J. avs., Collingswood
Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 618 Benson st., Camden
Deibert, Kirk R., 159 Elm av., Woodlynne
Del Duca, Vincent P., 406 Cooper st., Camden
Dempsey, J. Harvey, Washington av., Berlin
Denbo, Elic A., 854 Haddon av., Camden
Driscoll, Chas. D., Grant & W. Horse Pk., W. Coll'gsw'd
Eaton, Arthur T., 201 4th av., Haddon Heights
Ebner, Paul G., 719 Cooper st., Camden
Ellis, Alexander, 513 Broadway, Camden
Elwell, Alfred M., 407 Cooper st., Camden
Ewing, Leslie H., 10 Broad st., Berlin
Eynon, Harold K., 579 Haddon av., Collingswood
Farrell, Edgar A., 25 Kings Highway W., Haddonf'd
Fessman, John W., Clements Bridge rd., Runnemede
Filkins, Cedric E., 418 White Horse Pike, Audubon
Fridrich, Harry E., 4172 Federal st., Camden
Gamon, Robert S., 527 Cooper st., Camden
Geissler, Elmer E., 327 Monmouth st., Gloucester
German, Geo. B., 429 Cooper st., Camden

Gilson, John A., Jr., 220 8th av., Haddon Heights
Girardo, Anthony J., Bates av., W. Berlin
Glover, Lawrence L., 53 King's Hghwy. W., Had'n'd
Goldman, Samuel, 7th & State sts., Camden
Goldstein, Hyman I., 1425 Broadway, Camden
Gordon, Milton H., 12 N. 27th st., Camden
Grenhart, Geo. W., 430 Haddon av., Camden
Griffey, Wm. C., 132 Haddon av., Westmont
Hadley, C. Frazer, 210 W. Maple av., Merchantville
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont
Haines, Mabel S., 600 White Horse Pk., Audubon
Haines, Wm. H., 600 White Horse Pike, Audubon
Hallinger, Earl S., 517 Cooper st., Camden
Hammett, Lee J., 760 N. 27th st., Camden
Hanson, Alfred S., 533 Monmouth st., Gloucester
Hays, Roy G., 567 Haddon av., Collingswood
Hemphill, E. H., 232 Kings Highway E., Haddon'd
Hessert, Edmund C., 700 Haddon av., Collingswood
Hirst, E. Reed, 634 Federal st., Camden
Hollinshead, Beulah S., 600 Benson st., Camden
Horner-Rodger, Clara L., 721 Cooper st., Camden
Howard, J. Edgar, 67 King's Hghwy. W., Had'n'd
Hummel, Ernest G., 414 Cooper st., Camden
Hummel, Merwin L., 135 N. Centre st., Merch'tville
Husted, Gerald W., 306 8th av., Haddon Heights
Hutcheson, Chas. R., 517 Cooper st., Camden
Ironside, Paul A., 571 Benson st., Camden
Jack, H. Wesley, 517 Cooper st., Camden
Jackson, Chas. H., 1250 Park Blvd., Camden
Jarrett, Harry, 923 Broadway, Camden
Jones, John C., 805 Princeton av., Camden
Kain, Thomas M., 403 Cooper st., Camden
Keyser, David, 1518 Baird av., Camden
Kinney, Albert G., 917 Haddon av., Collingswood
Kline, Oram R., 414 Cooper st., Camden
Kutner, Chas., 1005 S. 5th st., Camden
Larossa, Ernest A., 640 Federal st., Camden
Lee, Thomas B., 622 Cooper st., Camden
Lewis, Thos. K., 47 S. 27th st., Camden
Lovett, Jos. C., Municipal Hospital, Camden
Lyon, Leslie C., P. O. Box 63, Magnolia
MacAlpine, Kenneth B., 308 Monm'th st., Gl'c'st'r'C'y
Madden, Theophilus W., 16 Frazer av., Collingsw'd
Magee, Russell S., 201 White Horse Pike, Audubon
Mahaffey, J. Lynn, 406 Warwick rd., Haddonfield
Maldeis, Albertos M. K., 117 North 6th st., Camden
Marcarian, Henry G., 904 Cooper st., Camden
Marcy, John W., 117 E. Park av., Merchantville
McCallum, Arthur S., 213 Clem'ts Br.Rd., Barrington
McCarthy, Arthur M., 2772 Federal st., Camden
McConaghy, Thos. P., cor 10th & Cooper sts., Camd'n
McDermott, Vincent T., 511 State st., Camden
McGlade, Thos. H., 2953 Yorkshop Sq., Camden
McWilliams, Charles E., Blackwood
Mecray, Paul M., 405 Cooper st., Camden
Mengel, Willard G., 400 Penn st., Camden
Meyer, George P., 410 Haddon av., Camden
Miller-Richardson, Emma, 581 Stevens st., Camden
Moore, Frank F., 201 Evergreen av., Woodlynne
Murray, Edwin N., 558 Newton av., Camden
Murray, Nelson T., 244 Stratford av., Westmont
Newmeyer, Joseph, 701 Broadway, Camden
Ondovchak, M. Frederic, King's Hgwy., Mt.Ephraim
Ornaf, I. Edward, 1145 Thurman st., Camden
Osmun, Milton M., 611 Broadway, Camden
Palm, Howard F., 614 N. 2nd st., Camden
Phillips, Claude B., 891 Haddon av., Collingswood
Pike, Charles E., 4 E. Haddon av., Oaklyn
Pinsky, M. Meyer, 944 S. 5th st., Camden

Pratt, Arthur G., 516 Cooper st., Camden
Pratt, William H., 516 Cooper st., Camden
Principato, Roberto, 402 Walnut st., Camden
Raughley, Wm. C., Taunton av., Berlin
Read, William T., Jr., Cooper Hospital, Camden
Rhone, David S., 1202 Haddon av., Camden
Ristine, Edwin R., 123 Maple av., Westville
Roberts, Jos. E., Jr., 403 Cooper st., Camden
Rogers, Edward B., 814 Haddon av., Collingswood
Rossell, Edward W., 801 Cooper st., Camden
Ruttenberg, Max, 303 Cooper st., Camden
Santor, G. Frank, 3176 Westfield av., Camden
Saunders, Orris W., 1700 Broadway, Camden
Schall, Reuben E., 537 N. 7th st., Camden
Scheffler, W. A. H., 511 Cooper st., Camden
Schellenger, E. A. Y., 429 Cooper st., Camden
Schrack, Helen F., 216 N. 5th st., Camden
Schwartz, Henry C., Raritan av., Atco
Scruggs, William J., 3005 Kearsarge rd., Camden
Shafer, Albert H., 405 Cooper st., Camden
Shafer, F. William, 634 Penn st., Camden
Sharp, Jennie S., 719 Cooper st., Camden
Sharp, Reuben L., 719 Cooper st., Camden
Shaw, Ernest B., 811 Collings av., W. Collingswood
Sheaffer, Clinton P., 241 King's Hghwy. E., Had'n'd
Shemeley, Wm. G., Jr., 7 Haddon av., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shipman, Jas. S., 542 Cooper st., Camden
Shope, Edward P., 511 Cooper st., Camden
Shull, Elliott C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Smith, Bertram H., 315 W. King's Hghwy., Audubon
Smith, James D., 701 N. 6th st., Camden
Smith, Wilbur A., 2 E. Clinton av., Oaklyn
Sochacki, Alexander, 1478 Mt. Ephraim av., Camden
Stein, Joseph M., 956 Newton av., Camden
Stephenson, Daniel H., 213 Haddon av., Haddonfield
Stone, Arthur L., 2838 Berkeley st., Camden
Sufirin, Emanuel, 119 N. 27th st., Camden
Summerill, Garnett, 330 Cooper st., Camden
Swiecicki, Martin E., 317 Clements Br. rd., Barringt'n
Tatem, Henry R., Jr., Pine st.&Atlantic av., Audubon
Thompson, Penrose H., 4612 Westfield av., Camden
Van Sciver, John E. L., 106 Broadway, Camden
Ward, Lettie A., Woodland av., Woodbury Heights
Warwick, Ralph A., 3300 Federal st., Camden
Watkins, George R., La Pierre av., Magnolia
Waugh, Bascom S., 1878 S. 10th st., Camden
Weimann, M. L., 803 Station av., Haddon Heights
West, Gordon F., 527 Penn st., Camden
Wheatland, Marcus F., 757 Kaighn av., Camden
Wiant, Herman E., 120 Windsor av., Haddonfield
Williams, Wm. C., Bl'ckHrs.Pk.&Wayne av., H'd'nHt.
Wilson, Isam E., 110 Chapel av., Merchantville
Wilson, Lester R., 3320 Federal st., Camden
Wright, Ralph S., 428 Richie av., Collingswood
Wroblewski, Benj. M., 1166 Thurman st., Camden

Honorary Members

Day, Grafton E., Collingswood
Marcy, John W., 117 E. Park av., Merchantville
Osmun, Milton M., 611 Broadway, Camden
Ward, Lettie, Woodbury Heights

Transferred

Gilbert, Philip D., from Philadelphia Co. Med. Soc.

Number of Active Members and basis of representation, 183, March 15, 1939.

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Four regular meetings each year. Meets on first Tuesday in April and October. Annual Meeting in November. Semi-annual meeting in April. Other two meetings at call of the President.

Active Members

Bernheisel, Louis E., Reading av., Tuckahoe
Brooks, George M., Cape May Court House
Cameron, C. Paul, 401 Atlantic av., Ocean City
Corson, Allen, 824 Wesley av., Ocean City
Crowe, Aldrich C., 735 Atlantic av., Ocean City
Cryder, Millard C., Cape May Court House
Dandois, George F., 220 E. Wildwood av., Wildwood
Friedland, Arnold J., Woodbine
Gidding, Samuel S., 154 E. Spicer av., Wildwood
Haines, Willits P., 601 9th st., Ocean City
Hornstine, Harry H., 4015 Pacific av., Wildwood
Hughes, Frank R., Columbia av. & Oc'n st., Cape M'y
Hughes, Samuel B., Pine & Pacific avs., Wildwood
Jennings, Edw. C., R. F. D. No. 1, Cape May C'ths.
Jonas, August, 218 E. Pine av., Wildwood
Mace, Margaret, 2410 Atlantic av., N. Wildwood

Monosson-Friedland, Ida, Woodbine
Pettit, Herschel, 807 Wesley av., Ocean City
Robbins, Warren D., 202 Ocean av., Cape May
Smith, Marcia V., 821 Wesley av., Ocean City
Steel, William A., Beesley's Point
*Tomlin, H. Hurlburt, Magn'lia & Atl'ntic avs., Wildw'd
Townsend, John B., 824 Wesley av., Ocean City
Way, Clarence W., Sea Isle City
Way, Julius, Cape May Court House
Whiticar, John H., 717 Wesley av., Ocean City

Resigned

Pressman, Abraham, Woodbine

Number of Active Members and basis of representation, 26, March 15, 1939.

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April.

Active Members

Aitken, Frank J. T., 20 N. Pearl st., Bridgeton
Bacon, Mary, 278 E. Commerce st., Bridgeton
Baker, Clifford, 800 Elmer st., Vineland
Baker, Hugh W., 8th & Elmer sts., Vineland
Bellak, Ellis R., Leesburg
Bennett, Samuel D., 118 Pine st., Millville
Berkowitz, Benj., 20 Bank st., Bridgeton
Bostwick, Delazon S., Cumberland Hotel, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Butcher, Charles, Heislerville
Clippinger, Richard D., 220 S. West av., Vineland
Cornwell, Alfred, 265 N. Laurel st., Bridgeton
Corson, Elton S., 133 E. Commerce st., Bridgeton
Corson, Kenneth E., 25 S. Myrtle st., Vineland
Cunningham, Charles, 75 Wood st., Vineland
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Main st., Port Norris
Garrison, W. Sherman, Main st., Cedarville
Giacalone, Vincent, 649 Landis av., Vineland
Gray, Charles M., 6th & Grape sts., Vineland
Kauffmann, Louis J., 228 N. 2nd st., Millville
Knowles, James S., 318 N. 2nd st., Millville
Kratka, Wm. H., 119 N. Pearl st., Bridgeton
Lihn, Barney, 611 Elmer st., Vineland
Lore, Harry E., Main st., Cedarville
Lyon, Earl C., 194 E. Commerce st., Bridgeton
Magolda, Anthony F., 727 Grape st., Vineland
Marchione, Nicholas E., 109 S. 7th st., Vineland
Mayhew, Charles H., 329 Pine st., Millville
Mezzetti, Alfred F., 226 S. 6th st., Vineland
Miller, H. Garrett, 203 E. Main st., Millville
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Neal, Charles B., Pine & 3rd sts., Millville
Pino, Anthony, 196 Irving av., Bridgeton

Ramsey, F. Muriel, 310 E. Pine st., Millville
Reeves, J. Franklin, 55 East av., Bridgeton
Sewall, Millard F., 195 E. Commerce st., Bridgeton
Sharp, Charles E., Main st., Port Norris
Sheppard, A. G., 309 Broad st., Elmer
Sheppard, Frank R., 131 N. 3rd st., Millville
Sheppard, Muse A., Penn & Broad sts., Elmer
Shirlock, Margaret E., Vinel'd Tr'n'g School, Vinel'd
Thalheimer, Edward J., 644 Plum st., Vineland
Thomas, George N., 712 Wood st., Vineland
Van Deusen, Edwin H., 12 N. 7th st., Vineland
Wainwright, Frederick P., 87 Bank st., Bridgeton
Walker, Ada H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Shiloh
Weithaase, Helen E., 803 Elmer st., Vineland
Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Charles W., 636 Wood st., Vineland
Wilson, Herbert B., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 630 Landis av., Vineland

Honorary Members

Elmer, Matthew K., 3 Franklin st., Bridgeton
Harris, Allan, Greenwich
Lloyd, Reba, Ivy Hall Sanitarium, Bridgeton
Simkins, Raymond, 117 Broad st., Bridgeton

Transferred

Baker, Clifford, from New York State
Shirlock, Margaret, from Somerset Co. Med. Society

Number of Active Members and basis of representation, 55, March 15, 1939.

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is second Thursday in May.

Active Members

Abel, Arthur R., 144 Harrison st., East Orange
Abrams, Abram B., 299 Clinton av., Newark
Adelman, Benjamin B., 190 Clinton av., Newark
Agnew, Hobart M., 144 S. Harrison st., East Orange
Albano, Edwin H., 242 Clifton av., Newark
Albano, Joseph, 535 N. 7th st., Newark
Alcamo, John H., 215 Littleton av., Newark
Alford, Ralph I., 83 Park st., Montclair
Allan, James S., 144 Harrison st., East Orange
Allen, Chester B., Jr., 254 Midland av., Montclair
Allen, G. Herbert, 181 Roseville av., Newark
Alling, Frederic A., 15 Washington st., Newark
Altman, Charles D., 301 Highland av., Newark
Ambrose, Anthony, 71 Congress st., Newark
Anderson, Robert C., 519 Sanford av., Newark
Angelillo, Marc C., 169 Bloomfield av., Newark
Antonius, Nicholas A., 27 W. Market st., Newark
Antopol, William A., 201 Lyons av., Newark
Anuario, Charles B., 283 S. Centre st., Orange
Applebaum, Irving L., 152 Clinton av., Newark
Areson, Wm. H., 153 Bellevue av., Upper Montclair
Ash, Samuel, 25 Johnson av., Newark
Asher, Maurice, 186 Clinton av., Newark
Aszody, Paul, 340 Waverly av., Newark
Avidan, Maurice S., 30 Stratford pl., Newark
Bachmann, Wm., 87 Hillcrest ter., East Orange
Bacote, Ernest F., 78 Barclay st., Newark
Bagg, Linus W., 31 Lincoln Park, Newark
Baiocchi, Pascal J., 203 Hunterdon st., Newark
Baird, Thompson M., 124 Grand pl., Arlington
Baker, Charles F., 198 Clinton av., Newark
Baker, Maclyn M., 638 Stuyvesant av., Irvington
Baldwin, Samuel H., 626 Clinton av., Newark
Banks, Winifred D., 6 N. Munn av., East Orange
Barkhorn, Charles W., 223 Roseville av., Newark
Barkhorn, Henry C., 45 Johnson av., Newark
Barnard, Frank G., 22 Plymouth st., Montclair
Barrett, John E., 635 Summer av., Newark
Barrett, Jos. F., 230 Parker av., Maplewood
Bass, Rose D., 54 Lyons av., Newark
Baum, Felix, 765 S. 10th st., Newark
Baum, Samuel, 10 Osborne ter., Newark
Bauman, Everett O., 17 Hillside av., Newark
Bauman, Rush C., 92 High st., Nutley
Becker, Frederick W., 14 Clinton pl., Newark
Becker, Martin, 351 Halsted st., East Orange
Becket, George C., 350 Springdale av., East Orange
Beling, C. Abbott, 111 Clinton av., Newark
Beling, Chris. C., 111 Clinton av., Newark
Bell, Horace O., Essex Co. Hosp. Cont. Dis., Belleville
Bell, Thomas, 340 Belmont av., Newark
Benedict, Alfred C., 121 Irvington av., South Orange
Bennett, Wm. F., Essex Mt. Sanatorium, Verona
Berardinelli, Carmine G., 92 8th av., Newark
Berg, Samuel, 156 Roseville av., Newark
Berger, Wm. A., 346 Roseville av., Newark
Bergman, Meyer W., 31 Lincoln Park, Newark
Berman, H. Robert, 286 Roseville av., Newark
Bernhard, Wm. G., Countryside dr., Murray Hill
Bernstein, Arthur, 330 Belmont av., Newark
Beyer, Othmar J., 42 Laurel av., Irvington
Bianchi, Angelo R., 184 Hunterdon st., Newark
Bien, Frank A., 999 Clinton av., Irvington
Bigelow, Elizabeth F. F., 120 Prospect st., S. Orange
Bigelow, Nelson S., 120 Prospect st., South Orange
Bingham, Arthur W., 144 Harrison st., E. Orange
Birdsall, Clarence A., 9 Smull av., Caldwell
Bissett, John V., 29 Hawthorne av., East Orange

Biunno, Anthony J., 53 Finlay pl., Newark
Blackburne, George, 490 Central av., Newark
Blanchard, Kenneth, 25 S. Munn av., East Orange
Blaustein, Maurice L., 37 Hillside av., Newark
Blauvelt, Harold, 46 Parker av., Maplewood
Bleiberg, Jacob, 565 Bergen st., Newark
Bleick, Theodore E., 61 Van Ness pl., Newark
Bleick, William D., 583 Prospect st., Maplewood
Bleier, Louis, 239 Lafayette st., Newark
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
Block, Milton, 711 Chancellor av., Irvington
Bocchini, Jos. A., 366 S. 12th st., Newark
Bokor, Emery, 819 S. 12th st., Newark
Bolton, Bernard, 291 Osborne ter., Newark
Borsher, Irving P., 249 Broad st., Bloomfield
Bove, Joseph, 306 Lincoln av., Orange
Brackett, Elizabeth R., 371 Franklin av., Nutley
Bradford, Stella S., 16 Seymour st., Montclair
Bradshaw, John H., 27 High st., Orange
Brakeley, Elizabeth, 71 Myrtle av., Montclair
Brams, William M., 7 Madison av., Newark
Brandman, Otto, 83 Johnson av., Newark
Braun, Gustav A., 221 S. Orange av., Newark
Brien, William M., 449 Main st., Orange
Briggs, Henry, 144 Harrison st., East Orange
Brim, Anne J. S., Hotel Edgemere, East Orange
Broadnax, Mary E., 140 Roseville av., Newark
Brodkin, Eva T., 365 Osborne ter., Newark
Brodkin, Henry A., 365 Osborne ter., Newark
Brotman, Morton M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Chester T., Prudential Ins. Co., Newark
Brown, Harold W., 27 S. Fullerton av., Montclair
Brown, Lewis W., 160 Roseville av., Newark
Brown, Richard J., 105 Ridgewood rd., So. Orange
Buckley, J. L., 666 Franklin av., Nutley
Budington, Walter I., 24 Commerce st., Newark
Bugbee, Frederick C., 132 Sunset av., Verona
Bull, Louis M., 92 Heller Parkway, Newark
Bull, Robert I., 361 Lafayette st., Newark
Bull, William J., 93 Park st., Montclair
Burke, Leonard P., 30 Lakeside av., Verona
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burns, Edward L., 269 Broad st., Newark
Burpeau, Wm. P., 144 Harrison st., East Orange
Burstein, Frank, 402 Clinton av., Newark
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
Butler, Eustace C., 249 Bloomfield av., Caldwell
Buvinger, Chas. W., 50 Washington st., East Orange
Byck, Louis, 114 Lyons av., Newark
Cacciarelli, Robert A., 517 Roseville av., Newark
Caggiano, Anthony P., 237 Grove st., Montclair
Cahill, Laurence A., 361 Lafayette st., Newark
Calasibetta, Chas. J., 37 Longfellow av., Newark
Caldwell, Donald M., Prudential Ins. Co., Newark
Caldwell, Julius A., 45 S. Mountain av., Montclair
Calvert, Wm. C., 225 Gregory av., West Orange
Camche, Leo J., 250 Renner av., Newark
Cameron, Edwin A., 186 S. Burnett st., East Orange
Campbell, Wm., 144 Harrison st., East Orange
Caputo, Anthony R., 217 Belleville av., Belleville
Carbone, Francesco N., 157 Hunterdon st., Newark
Cardwell, Edgar P., 47 Central av., Newark
Carman, Fletcher F., 31 Lincoln Park, Newark
Carrigan, Francis P., 516 Prospect st., Maplewood
Carrol, Wilfred, 56 Goodwin av., Newark

- Casale, John B., 359 Bloomfield av., Newark
 Cater, Douglas A., 57 South Harrison st., E. Orange
 Cerone, Daniel M., 309 First av., Newark
 Cestone, Canio, 521 Pompton av., Cedar Grove
 Chamberlain, Aims R., 30 Lenox pl., Maplewood
 Chamberlain, Richard R., 30 Lenox pl., Maplewood
 Champlin, Paul M., 43 S. Arlington av., E. Orange
 Chapman, Robert W., 835 Bergen st., Newark
 Cherashore, Harry N., 363 Centre st., Nutley
 Chiger, Alexander S., 621 High st., Newark
 Chimacoff, Hyman, 171 Elizabeth av., Newark
 Chmelnik, Abraham G., 299 Clinton av., Newark
 Clark, James H., 108 Orange rd., Montclair
 Clarcken, Jos. A., 43 Lincoln Park, Newark
 Claus, C. Hermann, 776 S. 19th st., Newark
 Clement, Baxter L., 31 Lincoln Park, Newark
 Clinton, Joseph A., 339 Park av., Newark
 Coe, Richard, 156 Clinton av., Newark
 Coffin, Henry F., 433 Mt. Prospect av., Newark
 Coghlan, Jasper, 540 Parker st., Newark
 Cohen, I. Elvin, 561 Elizabeth av., Newark
 Cohen, Maurice, 106 Valley rd., Montclair
 Cohen, Max, 60 Ridge rd., N. Arlington
 Cohen, Meyer J., 118 Johnson av., Newark
 Cohen, Sidney A., 283 Clinton pl., Newark
 Cohen, Sidney L., 20 Avon av., Newark
 Cohen, Sidney P., 512 Franklin av., Nutley
 Cohn, Hermann, 393 Clinton av., Newark
 Cohn, Royal M., 740 Clinton av., Newark
 Colmer, Meyer J., 31 Lincoln Park, Newark
 Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
 Colton, Ethan T., Jr., 31 Park st., Montclair
 Comando, Harry N., 690 Clinton av., Newark
 Condon, John F., 686 Mt. Prospect av., Newark
 Conlon, Philip J., 25 James st., Newark
 Connamacher, Harold S., 671 Springfield av., Newk
 Connolly, John J., 180 Ballantine Pkwy., Newark
 Connolly, Richard N., Newark City Hospital, Newk
 Cook, Hugh F., 21 Roseville av., Newark
 Cooke, William H., 303 Main st., East Orange
 Cooperman, Wm., 647 Market st., Newark
 Cornish, Charles H., 673 Prospect st., Maplewood
 Coughlan, Ella A., 10 Oakwood av., Orange
 Coughlin, Frank J., 100 Magnolia av., Arlington
 Cox, John C., 55 Woodland rd., Maplewood
 Cox, William W., 79 S. Fullerton av., Montclair
 Crane, Chas. G., 78 Farley av., Newark
 Crapanzano, Domenica, Essex Co. Hosp., Cedar Gr.
 Craster, Chas. V., Plane & William sts., Newark
 Crawford, Georgina U., 28 Carnegie av., E. Orange
 Crecca, William D., 111 Park av., Newark
 Cregar, John S., 160 Harrison st., East Orange
 Crossfield, Henry C., 144 Harrison st., East Orange
 Crystell, Edward H., 4 Hawthorne av., Nutley
 Curtis, Elbert A., 65 Central av., Newark
 D'Addario, Anthony R., 108 Broadway, Newark
 D'Agostini, Alfred J., 41 Columbia av., Newark
 Dane, Chas., 61 Scotland rd., South Orange
 Dane, John, 61 Scotland rd., South Orange
 D'Angelò, Joseph C., 330 Washington av., Belleville
 Danzis, Maximillian, 31 Lincoln Park, Newark
 Darden, Walter T., 149 W. Kinney st., Newark
 Davenport, Peter B., 764 S. Orange av., Newark
 Davidson, Henry A., 31 Lincoln Park, Newark
 Davidson, Louis L., 31 Lincoln Park, Newark
 Davies, Geo. W., 35 Fairview av., Verona
 Davis, Louis, 825 S. 10th st., Newark
 Davis, Thomas C., 30 Old Short Hills rd., Millburn
 DeFronzo, Morando, 180 Fairmount av., Newark
 Deignan, Wm. L., 257 Dodd st., East Orange
 Del Deo, Nicholas V., 49 State st., Newark
 Del Guercio, Olindo, 365 Bloomfield av., Newark
 Della Fera, L. F., 206 First av., Newark
 DeMichele, Roland V., 359 Clifton av., Newark
 Denes, Oscar, 402 Centre st., Nutley
 DePalma, Anthony F., 242 Clifton av., Newark
 DeTroia, Frederick C., 40 12th av., Newark
 Deutel, Oscar R., 283 Franklin st., Bloomfield
 De Vincentis, Henry, 285 Henry st., Orange
 Devlin, Frank, 617 Broadway, Newark
 Devlin, Hugh J., 72 Thomas st., Newark
 Dias, Joseph L., 17 Lombardy st., Newark
 Dieffenbach, Richard H., 570 Mt. Prosp't av., Newk
 DiGiacomo, Wm. H., 223 Fairmount av., Newark
 Dinge, Ferdinand C., 67 S. Munn av., East Orange
 Di Norcia, Joseph, 357 Third av., Newark
 Dodd, Edward L., 157 Forest st., Belleville
 Donahue, Wm. J., 71 S. 9th st., Newark
 Doremus, Widmer E., 375 Mt. Prospect av., Newark
 Dorn, Elliott I., 267 Vassar av., Newark
 Dowd, Ambrose F., 239 Broadway, Newark
 Dragonetti, Elvige N., 177 Clifton av., Newark
 Dranow, Paul, 233 Franklin av., Nutley
 Drapkin, Berta, 31 Lincoln Park, Newark
 Dreskin, Jacob L., 172 Lyons av., Newark
 DuBois, Morris G., 769 High st., Newark
 Dulin, Everett V., 144 Harrison st., East Orange
 Dunn, Theodore B., 395 Franklin st., Bloomfield
 Eagleton, Wells P., 15 Lombardy st., Newark
 Echikson, Joseph I., 845 S. 12th st., Newark
 Edelen, James J., 280 S. Clinton st., East Orange
 Ehrlich, William E., 31 Lincoln Park, Newark
 Eichler, Bernard B., 221 Midland av., Montclair
 Eigen, Louis A., 511 Valley rd., West Orange
 Ein, William B., 31 Lincoln Park, Newark
 Eisenberg, David S., 31 Lincoln Park, Newark
 Ellis, Arthur J., 282 Broad st., Newark
 Emerson, Linn, 310 Main st., Orange
 Emmer, S. Wolfe, Medical Tower, Newark
 Englander, Chas., 41 Hillside av., Newark
 English, John T., 681 Stuyvesant av., Irvington
 Epler, Don A., 45 Hillside av., Newark
 Epstein, Wm. M., 31 Lincoln Park, Newark
 Erler, Eugene W., 360 Irving av., South Orange
 Ervin, Millard B., 572 Prospect st., Maplewood
 Etheridge, Chas. H., 433 Prospect st., East Orange
 Evans, Chas. H., 144 Harrison st., East Orange
 Evans, David P., 144 Harrison st., East Orange
 Ewing, Harvey M., 31 Trinity pl., Montclair
 Fager, Rudolph O., 53 Park pl., Bloomfield
 Failing, Brayton E., 31 Lincoln Park, Newark
 Fanburg, Sol J., 31 Lincoln Park, Newark
 Farden, Joseph L., 342 Roseville av., Newark
 Farr, Irving L., 214 Walnut st., Montclair
 Faughnan, Rose C., 97 High st., Passaic
 Fechner, Julius, 362 Clinton av., Newark
 Fein, Bernard S., 585 Elizabeth av., Newark
 Fendrick, Edward, 17 Watson av., East Orange
 Feneck, Chas. C., Route 6, Box 330, Phoenix, Ariz.
 Fenichel, Benjamin, 69 Hillside av., Newark
 Ferguson, Wm. E., 22 James st., Newark
 Fern, Samuel S., 122 Elizabeth av., Newark
 Feuer, Jos. A., 654 Elm st., Arlington
 Fewsmith, Joseph L., 120 2nd av., Newark
 Fine, M. James, 65 Girard pl., Newark
 Finesilver, Edward M., 53 Lincoln Park, Newark
 Fink, Irving E., 129 Lyons av., Newark
 Finkel, Joshua, 368 Clinton av., Newark
 Finkelstein, Abe S., 670 Clinton av., Newark
 Finkler, Rita V. S., 35 Leslie st., Newark
 Finnerty, Urban R., 71 Park st., Montclair
 Fischer, Edward J., 29 Ashwood ter., West Orange
 Fischman, Harold H., 326 Avon av., Newark
 Fitzpatrick, Edw. F., 546 W. Market st., Newark
 Flanagan, John J., 173 Roseville av., Newark
 Flynn, Edward A., 161 Washington av., Belleville
 Foley, James F., 331 N. Grove st., East Orange
 Ford, Theodore R., 144 Harrison st., East Orange

Forsyth, Kenneth C., 611 Mt. Prospect av., Newark
Fort, J. Irving, 306 Roseville av., Newark
Forte, Frank S., 318 Roseville av., Newark
Fost, William H., 107 Franklin st., Belleville
Foster, Frank P., 2 Erwin Park, Montclair
Foster, Herbert W., 2 Erwin Park, Montclair
Foster, William S., 233 Mt. Prospect av., Newark
Fowler, Royale H., 744 Broad st., Newark
Fratantuno, Michael J., 152 W. Market st., Newark
Freeman, George C., Prudential Ins. Co., Newark
Freeman, Richard D., 103 Scotland rd., S. Orange
Freinkel, Jacob, 2 Hillside av., Newark
Friedman, Harry, 721 S. 16th st., Newark
Friedman, Hyman, 1096 Sanford av., Irvington
Friedman, Milton, 31 Lincoln Park, Newark
Froelich, Joseph C., 74 Ingraham pl., Newark
Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 299 Clinton av., Newark
Galioto, Frank M., 188 Ampere Pkwy., Bloomfield
Gamba, Jos., 345 Fairmount av., Newark
Gamsu, George, 2 Stratford pl., Newark
Ganley, Arthur J., 390 Park av., East Orange
Ganot, F. Irving, 392 Ridge st., Newark
Gantz, Emma O., 215 N. Grove st., East Orange
Gardam, Jos. W., 16 Longfellow av., Newark
Gardner, Kenneth E., 45 Fremont st., Bloomfield
Gauch, Wm., 177 Elwood av., Newark
Gelb, Jerome, 84 W. Alpine st., Newark
Gelber, Louis J., 550 Mt. Prospect av., Newark
Gennell, Ernest, 298 Parker st., Newark
George, Melbourne E. W., 744 Broad st., Newark
Gershenfeld, David B., 20 Hillside av., Newark
Giardina, John S., 341 Walnut st., Newark
Gibbins, Albert L., 119 Fifth st., Newark
Giffoniello, Arthur A., 200 Fairmount av., Newark
Gifford, Wm. R., 247 Park av., East Orange
Gilman, Chas. M. B., 59 Seeley av., Arlington
Ginsberg, Leon, Essex Co. Hosp., Cedar Grove
Giuffra, Frank, 99 Valley rd., Montclair
Glass, Oscar, 838 S. 12th st., Newark
Glass, Wm. H., 144 Harrison st., East Orange
Godfrey, Alan O., 220 Roseville av., Newark
Goeller, Jacob D., 1165 W. Clinton av., Irvington
Goffman, Emanuel, 316 Claremont av., Montclair
Goldberg, Harold H., 814 S. 10th st., Newark
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel A., 169 Gregory av., West Orange
Goldberg, Samuel M., 353 Washington av., Belleville
Golden, Clement H., 347 16th av., Irvington
Goldman, Jerome, 148 Chancellor av., Newark
Goldman, Lester M., 896 S. 16th st., Newark
Goldstein, Henry Z., 31 Lincoln Park, Newark
Goldstein, Samuel M., 40 Johnson av., Newark
Goldstein, Wm. H., 632 Belgrove dr., Kearny
Goodfellow, Gordon P., 196 Prospect st., E. Orange
Gordon, A. Julius, 351 Roseville av., Newark
Grady, Wm. F., 42 N. Fullerton av., Montclair
Graham, Richard B., 575 Belgrove dr., Arlington
Grant, William F., 309 Roseville av., Newark
Gray, John W., 142 Clinton av., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greenfield, Bernard H., 691 Clinton av., Newark
Greenfield, Leonard S., 691 Clinton av., Newark
Greenwald, Theo. L., 44 Maple av., Morristown
Greer, Melvin A., 190 Washington st., Bloomfield
Gregorius, Ralph F., 120 Irvington av., S. Orange
Gregory, Mildred G., 64 N. 9th st., Newark
Greifinger, Marcus H., 200 Ferry st., Newark
Griffin, Guy B., 197 S. Centre st., Orange
Griffith, Roy, 909 Broad st., Newark
Gross, Isidore, 60 Lakeside av., Verona
Grossblatt, Philip, 70 Baldwin av., Newark
Grunt, Louis, 404 Bergen st., Newark
Gulick, James B., 144 S. Harrison st., E. Orange

Gullord, Edw. G., 205 Alexander av., Up. Montclair
Guthrie, Wilson G., 300 Summer av., Newark
Gutowski, Walter T., 104 Grove ter., Irvington
Hadley, Elinor E., 5 Mountain av., Maplewood
Hagman, Frank E., 131 Ridge rd., N. Arlington
Hagney, Fred'k W., 669 Elizabeth av., Newark
Hahn, Katherine B., 372 Thornden st., South Orange
Hahn, William H., 15 Lombardy st., Newark
Haley, Paul W., 781 Sanford av., Newark
Halpern, Melvin M., 493 Central av., Newark
Halprin, Harry, 8 Washburn pl., Caldwell
Halsey, Levi W., 61 Church st., Montclair
Hamilton, Robert G., 92 Main st., Orange
Hanan, Jas. T., 11 The Crescent, Montclair
Hantman, Harold, 196 Roseville av., Newark
Harden, Albert S., 510 W. Market st., Newark
Harden, Albert S., Jr., 536 Ridgewood rd., Maplewood
Harhen, Geo. E., 22 Brookside av., Caldwell
Harvey, Robert K., 753 Kearny av., Arlington
Harvey, Thomas W., Jr., 59 Main st., Orange
Hasney, Frederick A., 292 Main st., West Orange
Hatcher, George A., Essex Co. Hosp., Cedar Grove
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington
Hauck, Wm. H., 644 Stuyvesant av., Irvington
Haussling, Francis R., 661 High st., Newark
Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Z., 84 Washington st., Newark
Hayes, Gerald W., 86 Hawthorne av., East Orange
Heineken, Theodore S., 17 Park pl., Bloomfield
Heller, Abraham R., 10 Kearny av., Kearny
Heller, Nathan B., 31 Lincoln Park, Newark
Henle, Carye-Belle, 671 Springfield av., Newark
Hennig, Paul F., 688 Stuyvesant av., Irvington
Hermann, John H., 197 S. Centre st., Orange
Herndon, Lewis S., 144 S. Harrison st., East Orange
Herold, Harvey T., 850 S. 13th st., Newark
Hersh, David H., 658 Springfield av., Newark
Hewson, Geo. F., 21 Roseville av., Newark
Hexamer, Fred, 50 Lyons av., Newark
Heyman, Arthur, 79 Baldwin av., Newark
Hill, Robert H., 339 Parker st., Newark
Hobart, Richard T., 454 Park st., Upper Montclair
Holland, Geo. A., 364 Clinton av., Newark
Holler, Henry G., 234 Montclair av., Newark
Holmes, Geo. J., 17 Elizabeth av., Newark
Hooton, Thos. C., 56 Church st., Montclair
Horn, Harry, 622 Stuyvesant av., Irvington
Horn, Max, 94 Lyons av., Newark
Horsford, Frederick C., 305 Broadway, Newark
Hosp, Paul H., 842 S. 12th st., Newark
Houck, William J., 207 Mt. Prospect av., Newark
Howard, James W., 87 Midland av., Montclair
Hubbard, Fayette E., 65 Church st., Montclair
Hubbard, Robert Y., 942 Sanford av., Irvington
Huber, Wm. H., 15 Salem st., Newark
Huberman, John, 853 S. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Hulett, Albert G., 20 Hawthorne av., East Orange
Humphries, Robert E., 637 Central av., East Orange
Hurff, J. Wallace, 86 Washington st., Newark
Husserl, Siegfried, 777 Clinton av., Newark
Hymowitz, Ben, 519 Belmont av., Newark
Ill, Carl H., 188 Clinton av., Newark
Ill, Charles L., 188 Clinton av., Newark
Ill, Edgar A., 1004 Broad st., Newark
Ill, Edmund W., 188 Clinton av., Newark
Ill, Edward J., 1004 Broad st., Newark
Ill, Herbert M., 188 Clinton av., Newark
Irwin, Jas. R., 330 Washington av., Belleville
Israeloff, Howard H., 1044 Clinton av., Irvington
Jackson, Albert F., 225 Hillside av., Nutley
Jackson, Elmer C., 98 Washington st., East Orange
Jacobs, William, 1013 Clinton av., Irvington
James, Bart M., 31 Lincoln Park, Newark

- James, Wm. L., 31 Lincoln Park, Newark
 Janifer, Clarence S., 208 Parker st., Newark
 Jaso, James V. Di., 710 Varsity rd., South Orange
 Jedel, Meyer, 125 4th st., Newark
 Jennings, Robt. E., 143 Park st., East Orange
 Jessurun, Samuel H., 613 High st., Newark
 Jones, Edward C., 183 Grove st., Montclair
 Jones, William R., 33 S. Fullerton av., Montclair
 Jonitz, Robert, 153 S. Grove st., East Orange
 Judge, John F., 33 Hazelwood av., Newark
 Just, Francis, 564 High st., Newark
 Kaderabek, Erwin J., 144 S. Harrison st., E. Orange
 Kahrs, Grace M., 140 Roseville av., Newark
 Kalb, Samuel W., 416 Clinton pl., Newark
 Kalter, George E., 640 Prospect st., Maplewood
 Kaminsky, Aaron L., 13 Poe av., Newark
 Kaplan, Benj. E., 695 Clinton av., Newark
 Kaplan, S. Bernard, 846 S. 12th st., Newark
 Katzin, Eugene M., 50 Baldwin av., Newark
 Kaufman, Jerome G., 299 Clinton av., Newark
 Kaufman, Michael J., 103 Lyons av., Newark
 Kavanaugh, Daniel E., 217 Broadway, Newark
 Kearney, Edward P. J., 83 S. Fullerton av., Montcl'r
 Keim, Wm. F., 25 Roseville av., Newark
 Keller, Paul, 15 Washington st., Newark
 Keller, Sidney C., 31 Lincoln Park, Newark
 Kenney, John A., 134 W. Kinney st., Newark
 Kern, E. Clarence, 45 Park st., Montclair
 Kessell, John S., 643 Central av., East Orange
 Kessler, Henry B., 666 Clinton av., Newark
 Kessler, Henry H., 53 Lincoln Park, Newark
 Kiley, John E., 94 Park st., Montclair
 Kimmel, Charles, 9 Eaton pl., Bloomfield
 Kirkby, Cyril S., 128 Broad st., Bloomfield
 Kirkman, Leroy G., 176 Roseville av., Newark
 Kirkwood, Allan S., 153 Union st., Montclair
 Klein, Andrew J. V., 209 Littleton av., Newark
 Klein, Edward C., Jr., 209 Littleton av., Newark
 Kleinberger, Harry H., 59 Main st., Millburn
 Klenk, Jos. P., 328 Belleville av., Bloomfield
 Kline, George L., 310 Mt. Prospect av., Newark
 Kobes, John J., 138 Kearny av., Kearny
 Kraemer, Manfred, 31 Lincoln Park, Newark
 Kraker, David A., 31 Lincoln Park, Newark
 Krone, William F., 31 Lincoln Park, Newark
 Kruger, William, 31 Lincoln Park, Newark
 Kummel, Max, 31 Lincoln Park, Newark
 Lafferty, Elton B., 330 Myrtle av., Irvington
 Landesman, William, 187 Kearny av., Kearny
 Lane, Austin W., 98 Prospect st., East Orange
 Lawless, Edward T., 85 Warrington pl., E. Orange
 Leaman, Granville M., 167 N. Grove st., E. Orange
 Le Bel, Louis J. B., 165 Grant av., Nutley
 Lee, John J., 309 Park av., Orange
 Lee, Stephen G., 55 Halsted st., East Orange
 Lehman, Irving J., 558 Central av., Newark
 Leonardis, Jas. V., 94 Jefferson st., Newark
 Levin, Jos., 831 South 13th st., Newark
 Levine, Philip, 201 Lyons av., Newark
 Levinson, Louis J., 18 Stratford pl., Newark
 Levitt, Jesse N., 26 Clinton pl., Newark
 Levy, Julius, 19 Lyons av., Newark
 Lewis, G. Rae, 458 Washington av., Belleville
 Lewis, Leon, 190 Clinton av., Newark
 Liccese, Emanuel, 84 Jefferson st., Newark
 Licks, Fred'k C., 117 Irvington av., South Orange
 Lieb, Saul, 337 Hawthorne av., Newark
 Lifland, Bernard D., 35 Shanley av., Newark
 Lilien, Bernard B., 730 Lyons av., Irvington
 Lincoln, Jennings S., 140 Watch'g av., Up. Montcl'r
 Livingston, Paul, 299 Main st., East Orange
 Loder, Joseph S., 924 S. 17th st., Newark
 Loeser, Lewis H., 31 Lincoln Park, Newark
 Longshore, Walter E., Jr., 216 Oakwood av., Orange
 Lottridge, Dorothy, 43 S. Maple av., East Orange
 Lovell, Frederick H., 1013 Clinton av., Irvington
 Lowenstein, Harry A., 96 Milford av., Newark
 Lowrey, Jas. H., 79 Congress st., Newark
 Lowy, Otto, 190 Clinton av., Newark
 Luban, Benjamin, 730 High st., Newark
 Luippold, Eugene J., Jr., 6 Fielding ct., S. Orange
 Lundblad, Walter E., 75 Prospect st., East Orange
 Luongo, Frederico, 212 S. Centre st., Orange
 Lurie, Wolf, 493 Watchung av., Bloomfield
 Lynch, Albert E. O., 257 Orange rd., Montclair
 Lyon, Archibald, 115 Ridge rd., N. Arlington
 Lyons, James V., 333 Park av., Orange
 Mabey, J. Corwin, Clarem't & Midland avs., Montcl'r
 Macaluso, Dominic C., 7 Hilton st., Belleville
 MacArt, James H., 74 S. Munn av., E. Orange
 MacArthur, Clymont, 219 Roseville av., Newark
 Macdonald, Wentworth S., 56 Church st., Montclair
 Macpherson, Elwood H., 34 Rawley pl., Millburn
 Maggio, Geo. A., 110 Fleming av., Newark
 Magovern, Thomas F., 228 S. Orange av., S. Orange
 Mahood, Herbert L., 86 Durand rd., Maplewood
 Mamlet, Alfred M., 16 Johnson av., Newark
 Mancusi-Ungaro, Elviro, 268 Mt. Prosp't av., New'k
 Mancusi-Ungaro, Lodovico, 156 Mt. Pr'sp't av., N'w'k
 Marcus, Donald, 640 Stuyvesant av., Irvington
 Margolis, Alfred, 218 West End av., Newark
 Margulies, Chas., 188 High st., Nutley
 Marks, Edward G., 655 Kearny av., Arlington
 Marks, Zelda I., 95 Wilson av., Newark
 Marquis, Dean W., 144 Harrison st., East Orange
 Marquis, William J., 198 Clinton av., Newark
 Marra, Rocco S., 221 Park av., Orange
 Martin, Wm. P., 25 Holland rd., South Orange
 Martinetti, Carlo D., 311 Central av., Orange
 Martland, Harrison S., Newark City Hosp., Newark
 Mason, Virgil A., 100 Chestnut st., East Orange
 Massengill, Fulton, 125 Harrison st., East Orange
 Masterson, John F., 98 Myrtle av., Irvington
 Matheke, Geo. A., 592 Park av., East Orange
 Matheke, Otto G., 328 Sussex av., Newark
 Matheson, Gilchrist E., 144 Harrison st., E. Orange
 Matthews, Clifford B., 1180 Raymond Blvd., Newark
 Matthews, Harry E., 504 Hillside av., Orange
 Matthews, Wm. F., 61 S. Fullerton av., Montclair
 Maurer, K. Virginia, 26 W. Northfield rd., Livingst'n
 May, Ernst A., 157 Harrison st., East Orange
 McBride, Hesser G., 1072 S. Orange av., Newark
 McCauley, Francis J., 31 Lincoln Park, Newark
 McCormick, Jas. E., 775 Elizabeth av., Newark
 McCroskery, Jas. H., 396 N. Arlington av., E. Orange
 McCullough, Walter A., Essex Co. Hosp., Cedar Gr.
 McKim, William F., 317 Roseville av., Newark
 McLellan, Geo. A., 19 Hawthorne av., East Orange
 McVay, Edward A., 234 Lafayette st., Newark
 Medd, John C., 25 Curtis pl., Maplewood
 Meehan, Martin M., 339 Washington av., Belleville
 Meeker, Irving A., 581 Valley rd., Upper Montclair
 Mellen, Stanley H., 863 Mt. Prospect av., Newark
 Menk, Paul E., 31 Lincoln Park, Newark
 Merkelbach, Walter P., 288 Broad st., Bloomfield
 Merliss, Eugene, 386 Clinton av., Newark
 Merselis, John G., 110 Irvington av., South Orange
 Meurlin, Alfred, 158 S. Harrison st., East Orange
 Mierau, Ernest W., 1096 Sanford av., Irvington
 Miller, Herman P., 815 S. 12th st., Newark
 Miller, Jos. A., 364 Prospect st., South Orange
 Miller, Ralph, 544 S. 16th st., Newark
 Minard, Edwy L., 140 4th av., East Orange
 Miningham, Wm. D., 18 Hedden ter., Newark
 Minnefor, Chas. A., 1164 S. Orange av., S. Orange
 Mishell, Daniel R., 31 Lincoln Park, Newark
 Mitchell, Augustus J., 59 South st., Newark
 Mockridge, Oscar A., 8 S. Mountain av., Montclair

MoECKel, Clarence W., 63 S. Fullerton av., Montclair
Mohrbacher, John J., 37 Osborne ter., Newark
Monaco, Saverio A., 293 Camden st., Newark
Moore, Dean C., 133 N. Arlington av., East Orange
Moore, John D., 6 Washington st., Bloomfield
Moretti, John J., 576 S. Clinton st., East Orange
Morgan, Browne, 2 Broad st., Bloomfield
Morris, Clement, 513 Broadway, Newark
Morrison, Caldwell, 379 7th av., Newark
Moschkowitz, Hermann, 737 High st., Newark
Motzenbecker, Peter F., 680 High st., Newark
Motzenbecker, Wm. J., 16 Milford av., Newark
Moulton, Chas. D., 122 Park av., East Orange
Mount, Walter B., 21 Plymouth st., Montclair
Mullin, Eugene F., 505 Sanford av., Newark
Mullin, Raymond J., 76 Shanley av., Newark
Murray, Harold A., 624 Mt. Prospect av., Newark
Muta, Samuel A., 47 Park av., West Orange
Nacca, Carl A., 86 N. Essex av., Orange
Nadel, Chas. I., 1186 Clinton av., Irvington
Nagler, Benedict, 25 Clinton pl., Newark
Nappi, Pasquale E., 250 Mt. Prospect av., Newark
Nash, Alexander E., 30 Forrest av., Verona
Nash, Herman S., 865 S. 11th st., Newark
Nash, Wm. G., 20 Clinton st., Newark
Nataro, Joseph, 172 Littleton av., Newark
Nemzek, Wm. P. B., 141 Ridge rd., N. Arlington
Nevius, William B., 610 Park av., East Orange
Newman, Grace T., 339 Grove st., Montclair
Newman, Julius, 31 Lincoln Park, Newark
Ney, Julian M., 671 Broad st., Newark
Nicola, Toufick, 96 Gates av., Montclair
Nimaroff, Meyer, 265 Union av., Irvington
Noll, Louis, 1333 Clinton av., Irvington
Norris, Henry M., 144 Harrison st., East Orange
Nussbaum, Harvey E., 89 Ferry st., Newark
Nyiri, William A., 30 Van Ness pl., Newark
O'Connor, Bernard A., 314 N. 4th st., Harrison
O'Connor, Dennis F., 671 Broad st., Newark
O'Connor, Michael J., 98 Shanley av., Newark
O'Crowley, Clarence R., 31 Lincoln Park, Newark
O'Grady, Michael J., 228 Franklin av., Nutley
Oleynick, Simeon A., 107 Clinton av., Newark
Olini, Joseph J., 30 W. Market st., Newark
O'Neill, Chas. L., 11 N. 7th st., Newark
Opdyke, Gordon McC., 52 Claremont av., Verona
Openchowski, Mieczyslaw, 83 Johnson av., Newark
Orloff, Samuel, 149 Lyons av., Newark
Orton, Henry B., 24 Commerce st., Newark
Paddock, Royce, 965 Broad st., Newark
Palmer, Gideon H., 28 Winans st., East Orange
Palmer, Henry S., 275 Mulberry st., Newark
Panitch, William, 90 Baldwin av., Newark
Pannell, Walter L., 243 S. Harrison st., East Orange
Pannullo, John N. P., 266 Van Buren st., Newark
Parent, Sol, 51 Baldwin av., Newark
Parisi, Anthony, 296 S. Orange av., Newark
Parker, John E., 144 Harrison st., East Orange
Parsonnet, Aaron E., 3 Madison av., Newark
Parsonnet, Eugene V., 31 Lincoln Park, Newark
Pascall, Thos. M., 197 Lincoln av., Newark
Pattyson, Ralph A., 144 Harrison st., East Orange
Paul, Geo. A., 788 Lyons av., Irvington
Paul, H. Carl, 30 Westville av., Caldwell
Pavia, John R., 95 N. Munn av., Newark
Payne, Guy, Overbrook Hosp., Cedar Grove
Payne, Guy, Jr., 56 S. Prospect st., Verona
Peer, Lyndon A., 965 Broad st., Newark
Pendexter, Sidney E., 11 S. Arlington av., E. Orange
Pennington, Alfred W., 398 N. Maple av., E. Orange
Perham, Bertram S., 199 Lorraine av., Up. Montcl'r
Perrone, Anthony J., 456 Roseville av., Newark
Pettry, William, 109 Treacy av., Newark
Phillips, Algernon A., 212 W. Market st., Newark

Pilch, Arthur G., 1 Willard av., Bloomfield
Pilloni, Louis, 91 Beach st., Bloomfield
Pizzi, Francis W., 205 Park av., Orange
Plant, James S., 502 High st., Newark
Plante, Amos A., 437 Ridgewood rd., Maplewood
Pois, John, 52 Pillot pl., West Orange
Pollis, Nicholas L., 642 High st., Newark
Pollock, Franklyn J., 14 Watson av., Newark
Polow, Benjamin, 24 Johnson av., Newark
Pomeranz, Raphael, 31 Lincoln Park, Newark
Potter, Raymond T., 144 Harrison st., East Orange
Prestifilippo, Silvestro, 115 Glen Ridge av., Montcl'r
Preston, Perry B., 12 Palm st., Newark
Price, Chas. W., Essex County Hosp., Cedar Grove
Price, Nathaniel G., 16 Johnson av., Newark
Probst, Everett W., 176 Camita av., Rutherford
Pudney, Wm. K., 31 Trinity pl., Montclair
Quad, Clifford W., 52 Northfield av., West Orange
Quinby, Wm. O'G., 14 James st., Newark
Rado, William, 75 Lincoln Park, Newark
Rados, Andrew, 31 Lincoln Park, Newark
Ragione, Mario D., 277 Clifton av., Newark
Ram, Nathan H., 34 Park av., Caldwell
Ranson, Briscoe B., Jr., 144 Harrison st., E. Orange
Rathgeber, Chas. F., 18 William st., East Orange
Ravitz, Samuel F., 1082 Broad st., Newark
Rawitz, Sidney B., 42 Chancellor av., Newark
Reeve-Allen, Jane, 254 Midland av., Montclair
Reich, Abraham L., 83 Lyons av., Newark
Reich, Henry, 31 Lincoln Park, Newark
Reilly, Christopher J., 331 13th av., Newark
Reilly, John V., 520 Sanford av., Newark
Reinfeld, Abraham G., 354 Clinton av., Newark
Reinhardt, Warren I., 276 Springdale av., E. Orange
Reissman, Erwin, 31 Lincoln Park, Newark
Reitter, George S., 71 Harrison st., East Orange
Renzulli, Francesco, 228 S. 7th st., Newark
RePass, Paul E., 85 Harrison st., East Orange
Resch, Henry U., 27 Park pl., Bloomfield
Rettig, Isidor L., 36 Milford av., Newark
Revere, Seth D., 600 Park av., East Orange
Ribbans, Robert C., 63 Central av., Newark
Rich, Charles, 191 Littleton av., Newark
Rich, Wallace E., Essex Co. Hosp., Cedar Grove
Richardson, Arthur H., 60 Orange rd., Montclair
Richardson, Marvin T., 14 E. Mt. Pt's'nt av., Liv'gst'n
Ricketts, Henry E., 31 Lincoln Park, Newark
Riggins, Edwin N., 161 N. Arlington av., E. Orange
Ripley, Chas. D., Curtis av., Point Pleasant Beach
Ripley, E. Warren, 56 Church st., Montclair
Rizzolo, Edward M., 523 Union av., Belleville
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Charles M., 31 Lincoln Park, Newark
Robbins, Eugene, 909 Broad st., Newark
Roberts, Allison H., 24 S. 9th st., Newark
Roberts, David C., 158 S. Harrison st., East Orange
Roberts, Frank A., 11 Park av., Caldwell
Roberts, William A., 11 Park av., Caldwell
Robertson, Euston S., 22 Harding ter., Kearny
Robie, Theodore R., 144 Harrison st., East Orange
Robins, David, 24 Commerce st., Newark
Robinson, Louis H., 31 Lincoln Park, Newark
Rocco, Frank, 729 Summer av., Newark
Roerber, Wm. J., 21 Nesbit ter., Irvington
Rogers, Richard M., 1 Wallace st., Newark
Rogers, Robert H., 49 9th av., Newark
Roles, Earl W., 25 N. Harrison st., East Orange
Romano, Patrick J., 203 S. Essex av., Orange
Rosamilla, Ralph E., 480 N. 7th st., Newark
Rosen, Charles D., 106 S. Harrison st., East Orange
Rosenberg, L. Charles, 11 Murray st., Newark
Rosenberg, Max, 23 Wyndmoor av., Hillside
Rosenthal, Sydney, 95 Wilson av., Newark
Roth, Oswald H., 210 Littleton av., Newark

- Rothhouse, Burnet, 31 Lincoln Park, Newark
 Rothschild, Daniel L., 585 Elizabeth av., Newark
 Rothseid, Abraham, 59 Avon av., Newark
 Rothstein, Isadore B., 16 Lyons av., Newark
 Rubin, Abraham A., 75 Lincoln Park, Newark
 Rubinow, Saul M., 755 High st., Newark
 Runyan, Wm. J., 106 Broad st., Bloomfield
 Rusby, Henry H., 143 Fifth st., Sarasota, Florida
 Russomanno, Raymond L., 227 Clifton av., Newark
 Samson, Norman D., 281 Kearny av., Kearny
 Santora, Philip J., 361 Roseville av., Newark
 Saslow, Benjamin I., 680 Clinton av., Newark
 Sasso, Albert, 99 Parker st., Newark
 Sax, Max T., 84 Grove st., Bloomfield
 Sbarra, Francesco C. N., 189 Roseville av., Newark
 Schaaf, Royal A., 413 Mt. Prospect av., Newark
 Schachter, Harry A. H., 6 Milford av., Newark
 Schaefer, Eugene P., 12 Harrison pl., Irvington
 Schaffer, Barney, 252 Washington av., Belleville
 Schaffer, Nathan, 172 S. Arlington av., East Orange
 Schechtman, Vera, 385 Osborne ter., Newark
 Scheller, George A., 701 Clinton av., Newark
 Scher, Maurice A., 137 Lyons av., Newark
 Schiffmann, Samuel, 107 Spruce st., Newark
 Schiller, Nicholas, 29 Girard pl., Newark
 Schmukler, Jacob, 29 Rutgers st., Maplewood
 Schneider, Charles A., 694 Clinton av., Newark
 Schneider, Louis, 874 S. 13th st., Newark
 Schoenau, Carl W., 1255 Broad st., Bloomfield
 Schotland, Clement E., 41 Leslie st., Newark
 Schramm, Joseph A., 572 High st., Newark
 Schreck, Harry, 192 Roseville av., Newark
 Schulsinger, Samuel, 80 Clinton av., Newark
 Schulte, Herbert A., 701 Clinton av., Newark
 Schults, Anna R., 207 Summer av., Newark
 Schurman, Francis H. C., 14 Smull av., Caldwell
 Scott, R. Hunter, 205 Roseville av., Newark
 Scranton, Chas. W., 59 Washington st., E. Orange
 Scudder, Frank D., 65 N. Fullerton av., Montclair
 Seidler, Victor B., 16 Plymouth st., Montclair
 Seidman, Edwin A., 580 High st., Newark
 Seifert, Edwin A., 415 Ridgewood av., Glen Ridge
 Sellers, Robert R., 19 Chestnut st., Newark
 Selvaggi, Carlo, 82 Congress st., Newark
 Seward, Wm. H., Orange Memorial Hosp., Orange
 Shack, David N., 712 Clinton av., Newark
 Shack, Maxwell H., 19 Lyons av., Newark
 Shaner, Ralph D., 94 Hillside av., Nutley
 Shannon, James B., 66 S. Fullerton av., Montclair
 Shannon, Lardner M., 66 S. Fullerton av., Montclair
 Shapiro, Louis, 146 Broad st., Newark
 Shaul, Frederick G., 10 Washington st., Bloomfield
 Shaw, John J., 127 Scheerer av., Newark
 Sheehan, Daniel C., 12 Cliff st., Newark
 Sherman, A. Russell, 671 Broad st., Newark
 Sherman, Alton L., 485 Park av., Orange
 Sherman, Arthur E., 243 S. Harrison st., E. Orange
 Sherman, Elbert S., 671 Broad st., Newark
 Shill, Benjamin, 738 High st., Newark
 Shor, David M., 32 S. Munn av., East Orange
 Shreehan, Hubert F., 620 Summer av., Newark
 Shulman, Murray W., 916 S. 20th st., Newark
 Siegel, Jacob W., 96 S. 10th st., Newark
 Silver, Harry B., 190 Clinton av., Newark
 Silverstein, Benj. J., 32 Hillside av., Newark
 Silverstein, Jacob M., 73 Main st., Millburn
 Simmons, Albert V., 720 Prospect st., Maplewood
 Simms, George F., 541 Page av., Lyndhurst
 Simon, Henry, 5 Vermont av., Newark
 Simon, Ludwig L., 201 Ferry st., Newark
 Singer, Max, 147 Johnson av., Newark
 Sisson, Nelson W., 144 Harrison st., East Orange
 Skwirsky, Joseph, 170 Hawthorne av., Newark
 Slavin, Paul, 31 Lincoln Park, Newark
 Smalley, Sara D., 530 Clifton av., Newark
 Smalzried, Elmer W., 69 Woodland av., E. Orange
 Smith, Byron J., 851 S. Orange av., East Orange
 Smith, Christopher A., 6 Park st., Roseland
 Smith, Ellis L., Soho Hospital, Belleville
 Smith, George H., 136 Evergreen pl., East Orange
 Smith, Harold W., 179 Lincoln av., Orange
 Smith, Henry G., Essex Co. Hosp., Cedar Grove
 Smith, Jos. J., 325 13th av., Newark
 Smith, Leonard H., 32 Washington st., E. Orange
 Smith, Thayer A., Forest dr. & Park pl., Short Hills
 Snavelly, Earl H., City Hospital, Newark
 Sobin, Julius, 24 Waverly av., Newark
 Solk, Arthur G., 88 Clinton av., Newark
 Somers, Fred L., 144 Harrison st., East Orange
 Soschin, Samuel J., 31 Lincoln Park, Newark
 Spallone, Joseph C., 123 Mt. Prospect av., Newark
 Spinner, Samuel L., 66 Goldsmith av., Newark
 Sprague, Edward W., 86 Washington st., Newark
 Staehle, Richard H., 34 Lyons av., Newark
 Stahl, Alfred, 55 Lincoln Park, Newark
 Stahl, Charles, 659 Sanford av., Newark
 Statman, Arthur J., 17 Leslie st., Newark
 Steiner, Edwin, 31 Lincoln Park, Newark
 Stewart, Robert G., 79 Midland av., Montclair
 Stickles, Lloyd C., 49 Parkhurst st., Newark
 Stiles, C. Campbell, 713 Park av., East Orange
 Stokes, Earle B., 144 Harrison st., East Orange
 Strack, Vincent J., 1072 S. Orange av., Newark
 Straub, Herbert H., 242 Springdale av., E. Orange
 Streen, Morris E., 908 Bergen st., Newark
 Sturchio, Edoardo, 104 Ferry st., Newark
 Suesserman, Henry, 389 Lyons av., Newark
 Sutton, Harold L., 777 High st., Newark
 Sutton, Jos. G., Essex Co. Hosp., Cedar Grove
 Szerlip, Leopold, 31 Lincoln Park, Newark
 Taff, Harry, 172 Roseville av., Newark
 Talbot, Herbert S., 16 Eppirt st., East Orange
 Tansey, Wm. A., 98 Dover st., Newark
 Tarbell, Harold A., 13 Pennington st., Newark
 Taylor, G. Herbert, 144 Harrison st., East Orange
 Teeter, Charles E., 418 Orange st., Newark
 Tenney, Albert S., 164 S. Harrison st., East Orange
 Thomas, John H., 270 Lenox av., South Orange
 Thomson, Harry E., 605 Broad st., Newark
 Thompson, Arthur F., 144 Harrison st., East Orange
 Thompson, Austin B., 479 Highland av., Orange
 Thomson, Carroll S., Fair Oaks Sanatorium, Summit
 Thornhill, Arthur C., 47 Forest st., Montclair
 Thum, Kurt W., 366 Main st., West Orange
 Tillis, Herman H., 11 Bergen st., Newark
 Tilton, William R., 763 Broad st., Newark
 Tirrell, C. Malcolm, 725 High st., Newark
 Tobey, Franklin J., 11 Hazelwood av., Newark
 Tomasulo, Gennaro L., 225 Clifton av., Newark
 Tomec, Richard F., 42 Melrose pl., Montclair
 Torppey, John J., 472 Sanford av., Newark
 Toye, John E., 90 Midland av., Arlington
 Trautwein, Charles F., 19 Treacy av., Newark
 Turi, Amedeo E., 57 Garside st., Newark
 Turner, Charles F., 151 Grove st., Montclair
 Tushnet, Leonard, 662 18th av., Irvington
 Tutschulte, Ernest, 111 Mt. Pleasant av., Newark
 Twitchell, Adelbert B., 162 S. Orange av., S. Orange
 Tymeson, Walter R., 310 Main st., Orange
 Ulan, Oscar, 170 Fleming av., Newark
 Ulvestad, Lawrence E., 147 Halsted st., E. Orange
 Urbach, George, 187 Chancellor av., Newark
 Vail, Herbert B., 301 Washington av., Belleville
 Vanderhoff, Irving M., 9 Clinton st., Newark
 Vander Veer, H. Garrett, 295 Montgom'ry st., Bl'mf'd
 Van Emburgh, Geo. H., 575 Belgrove dr., Arlington
 Van Gieson, Edward J., 70 Watsessing av., Bloomf'd
 Vannatta, Geo. W., 226 N. Park st., East Orange

Van Ness, H. Roy, 444 Parker st., Newark
Verbeck, George B., 26 Washburn pl., Caldwell
Virgilio, Anthony A., 87 S. Centre st., Orange
VonHofe, Frederick H., 75 Prospect st., E. Orange
Voorhees, Florence E., 140 Roseville av., Newark
Vreeland, Ralph D., L. Bamberger & Co., Newark
Wakeley, Wm. E., 144 Harrison st., East Orange
Waldron, Robert E., 1194 Broad st., Bloomfield
Wallhauser, Henry J. F., 31 Lincoln Park, Newark
Walsh, Charles R., 21 W. Mt. Pleasant av., Liv'gst'n
Walton, Ralph W., 102 Gates av., Montclair
Wambsganss, Magdalena, 44 Devine st., Newark
Ward, Elisabeth B., 112 Chancellor av., Newark
Ward, Gertrude P., 41 Park pl., Bloomfield
Ward, Wm. R., 112 Chancellor av., Newark
Warner, Wm. H. A., 444 Central av., East Orange
Waterman, Samuel M., 479 Elizabeth av., Newark
Weber, Francis C., 286 Mt. Prospect av., Newark
Webner, C. Fred., 71 Lincoln Park, Newark
Weeks, Norman E., 11 Seymour st., Montclair
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, Francis S., 189 16th av., Newark
Weinstein, Morris W., 643 Chancellor av., Irvington
Weinstock, Michael B., 13 Hillside av., Newark
Weiss, Louis, 519 Springfield av., Newark
Weiss, Selma, 2 Stratford pl., Newark
Weller, Arthur, 19 Hillyer st., Orange
Weston, Clifford G., 27 Woodland av., Glen Ridge
Wheeler, Wm. K., 31 Lincoln Park, Newark
Whelan, Edward P., 460 Franklin av., Nutley
Wherry, Elmer G., 325 Clinton av., Newark
White, Robert R., 25 S. Munn av., East Orange
Wilkes, Arthur C., 36 Osborne ter., Newark
Willan, Edward H., 74 S. Munn av., East Orange
Willey, F. Parker, 5 Park st., Bloomfield
Williams, John J., 88 Walnut st., Newark
Willner, Irving, 18 Waverly av., Newark
Willson, James H., 144 Harrison st., East Orange
Wilson, John H., Jr., 85 Halsted st., East Orange
Wolf, Raymond E., 331 Gregory av., West Orange
Wolfe, Jacob S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
Wood, E. LeRoy, 160 Roseville av., Newark
Woolf, Bernhardt H., 15 Hedden ter., Newark
Wort, Frederick J., 1080 Broad st., Newark
Wrensch, Alex. E., 79 Valley rd., Montclair
Wright, Robert E., 173 Park av., East Orange
Wurts, Margaret M., 12 Elston rd., Up. Montclair
Wurzel, Milton, 295 Hunterdon st., Newark
Wyatt, Joseph H., 135 Clinton av., Newark
Wyker, Arthur W., 57 Park pl., Bloomfield
Yadkowsky, Emanuel, 637 High st., Newark
Yaguda, Asher, 88 Clinton av., Newark
Yankowicz, Michael, 718 S. 17th st., Newark
Yates, Glen L., 330 Washington av., Belleville
Ylvisaker, Lauritz S., Pru. Ins. Co., 763Br'd st., N'w'k
Zager, Saul, 454 Hawthorne av., Newark
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmer, Wm., 83 Vassar av., Newark
Zimmerman, Coler, 52 N. Arlington av., E. Orange
Zingali, John A., 115 Glenridge av., Montclair
Zweibel, Leonard, 885 S. 13th st., Newark
Zweigel, Isidore, 22 Monticello av., Newark
Zybulewski, Edmund A., 410 Bergen st., Newark

Associate Members

Bancone, Albina V., 545 N. 7th st., Newark
Bernson, Samuel T., 653 S. 18th st., Newark
Besson, Franklin J., 999 Clinton av., Irvington
Byrnes, Elizabeth W., 142 Clinton av., Newark
Bythewood, Alton E., Jr., 145 W. Market st., New'k
Cott, Abe A., 730 Prospect st., Maplewood
D'Alessandro, Arthur J., 94 Boylan st., Newark
Del Negro, Albert E., 402 Roseville av., Newark
DePhillips, Benedict R., 43 Park av., Newark
Durchlag, E. Nelson, 12 Myrtle av., Irvington
Ehrlich, Edward, 79 Shanley av., Newark
Eisenberg, Harry, 473 Washington av., Belleville
Fader, Ferdinand, 3 S. Grove st., East Orange
Fischer, David D., 356 Millburn av., Millburn
Fissell, George McG., 333 Park av., Newark
Fleischmann, Viola G., 341 16th av., Irvington
Fleming, Joseph A., 247 Claremont av., Montclair
Forte, Daniel L., 545 Central av., Orange
Fortunato, Samuel J., 345 Walnut st., Newark
Gaylor, Earl L., Jr., 56 Church st., Montclair
Gibson, Augustus, 635 Valley rd., Upper Montclair
Greifinger, William, 619 Stuyvesant av., Irvington
Holtz, Harry M., 56 Johnson av., Newark
Howell, Thomas W., 47 Central av., Newark
Jones, Elwood K., 82 S. Harrison st., East Orange
Keith, Theodore R., 656 Bloomfield av., Nutley
Klosk, Emanuel, 808 S. 12th st., Newark
Koeck, George P., 625 Mt. Prospect av., Newark
Kunz, Harold G., 82 W. Passaic av., Bloomfield
Levison, William, 75 Lincoln Park, Newark
Lilien, Milton, 88 Norwood pl., Newark
Lutz, Wm. M., 3 Southern Slope dr., Millburn
Meinhard, Fred, 154 Van Buren st., Newark
Moss, Mary C., 5 Mountain av., Maplewood
Opacity, Ernest A., 247 Madison av., Newark
Parell, George C., 275 S. 7th st., Newark
Parkes, Morey, 43 Forest av., Caldwell
Pinto, Joseph A., 50 N. 11th st., Newark
Pizzi, Mario V., 205 Park av., Orange
Rachlin, Harry T., 396 Union av., Irvington
Reich, Mortimer, 31 Lincoln Park, Newark
Rosenbaum, Samuel X., 96 N. Walnut st., E. Orange
Rosenthal, Arnold J., 263 Clinton pl., Newark
Rothgesser, Jerome C., 786 Bergen st., Newark
Savel, Lewis E., 872 S. 16th st., Newark
Schwartzberg, Seymour H., Pier lane, R.F.D., Caldwl
Shechner, Isadore, 122 Broad st., Newark
Siegel, Jack G., 33 Johnson av., Newark
Strasser, Hans A., 569 Mt. Prospect av., Newark
Sullivan, Wm. T., 35 DeWitt av., Belleville
Vallario, Frank A., 333 Clifton av., Newark
Ward, William R., Jr., 112 Chancellor av., Newark
Willner, Philip, 105 Clinton av., Newark

Resigned

Kreeger, Morris H.
Lawrence, Minnie J.

Transferred

Lurie, Wolf, from Baltimore, Md.
Matthews, Clifford B., from Mercer Co. Med. Soc.
Morgenstern, Edward, to New York

Number of Active Members and basis of representation, 942, March 15, 1939.

GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July, and August. Annual Meeting in May. Annual Social Session in October.

Active Members

Barrows, Victor I., 316 N. Broadway, Pitman
Booth, George R., 219 Highland av., Westville
Bowersox, Clarence A., 106 S. Columbia av., W'db'ry
Brewer, Wm., 34 Cooper st., Woodbury
Burkett, J. Paul, 215 Delaware st., Woodbury
Burkett, Wendell J., 16 W. Holly av., Pitman
Carpenter, Wm. H., 39 Aberdeen pl., Woodbury
Collins, Louis K., 54 State st., Glassboro
Crain, Wm. E., 43 Curtis av., Woodbury
Diverty, Henry B., 38 Cooper st., Woodbury
*Downs, Elwood E., 7 S. Childs st., Woodbury
Fisler, Chas. F., 140 Maple st., Clayton
Fooder, Horace M., 110 Main st., Williamstown
Gardner, Thos. M., 319 W. Broad st., Gibbstown
Gillis, Alfred G., 19 W. Maple st., Clayton
Harris, Wm. G., Main st., Mullica Hill
Hillegass, Eugene Z., Main st., Mantua
Hollinshead, Ralph K., 351 Broadway, Westville
Hughes, Jos. F., 116 N. Broad st., Woodbury
Hunter, Harold H., 114 W. Broad st., Paulsboro
*Knight, I. Warner, 13½ S. Broadway, Pitman
Livengood, Baxter A., 406 2nd st., Swedesboro
Moore, Ralph L., 127 N. Broad st., Woodbury
Nelson, Harry, 36 Lupton av., Woodbury
Patterson, Isaac N., 230 Broadway, Westville
Pedrick, Wm. W., 11 West st., Glassboro
Pegau, Paul M., 246 Briar Hill lane, Woodbury
Rhoads, S. Creadick, 104 Station av., Westville
Rogers, Dorothy M., 50 Cooper st., Woodbury
Ruttenberg, Louis, Union st., Mantua
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 53 Newton av., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
Sirota, E. Bernard, 220 W. Broad st., Paulsboro
Sooy, Leslie T., 202 W. Holly av., Pitman
Stewart, Irving J., 529 Kings Highway, Swedesboro
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, J. Harris, 509 N. Broad st., Woodbury
Venturo, Ralph C., 101 S. Main st., Glassboro
Wandall, Frederick G., 50 E. High st., Clayton
Weems, Don B., 105 E. Mantua av., Wenonah
Wentzell, J. Earl, 5 E. Mantua av., Wenonah
Wood, Oran A., 128 W. Broad st., Paulsboro
Wright, Herman W., 318 S. Broadway, Pitman
Zapf, Reville D., 100 W. Mantua av., Wenonah

Number of Active Members and basis of representation, 45, March 15, 1939.

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day. Annual Meeting in May.

Active Members

Adler, Joseph, 933 Ave. C, Bayonne
Africano, Julius V., 4242 Hudson Blvd., Union City
Agolia, Michael W., 441 Palisade av., Union City
Ainsley, H. Bryson, 246 Union st., Jersey City
Allen, Isaac L., 521 Palisade av., Union City
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Amdur, Louis A., 2540 Boulevard, Jersey City
Andreae, Paul, 52 Warner av., Jersey City
Angelo, Jos. A., 10 Centre av., Secaucus
Arbeit, Sidney R., 2521 Boulevard, Jersey City
Aria, Michael H., 31 Glenwood av., Jersey City
Arndt, Frank Roy, 960 Bergenline av., N. Bergen
Ash, Arthur F., 710 Boulevard E., Weehawken
Atwell, David R., 920 Hudson st., Hoboken
Auriemma, Michele, 419 Adams st., Hoboken
Axford, Wm. H., Chester
Bahnsen, Conrad M., 170 Bowers st., Jersey City
Bailyn, Emanuel, 331 16th st., West New York
Ballinger, Reeve L., 659 Kearny av., Arlington
Barbarito, Wm. N., 135 Bentley av., Jersey City
Barishaw, Samuel B., 5 Bentley av., Jersey City
Barrett, Arthur F., 835 Montgomery st., Jersey City
Behrens, Herman H. E., 312 Webster av., Jer. City
Ben-Asher, Solomon, 260 Bergen av., Jersey City
Benjamin, Harold C., 59 Crescent av., Jersey City
Bergmeyer, Josef T., 422 20th st., West New York
Berlin, Joseph I., 2600 Hudson Blvd., Jersey City
Betcher, Albert M., 21 Highland av., Jersey City
Bigliani, Urban R., 526 36th st., North Bergen
Bitten, Robert M., 33 Romaine av., Jersey City
Blakey, Abram P., 155 Wegman Pkwy., Jersey City
Boland, Lucy E., 27 Washington av., Arlington
Bonanno, Peter J., 500 35th st., N. Bergen
Bookrajian, Edw. N., 5459 Boulevard, N. Bergen
Borrone, Milton G., 2695 Boulevard, Jersey City
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Boulevard, Jersey City
Boselli, Emile H., 614 15th st., Union City
Botti, John A., 236 Summit av., Jersey City
Bowyer, Franklin F., 50 Gifford av., Jersey City
Brady, Thomas S., 678 Ave. C, Bayonne
Braitman, Max, 412 16th st., West New York
Branch, Wm. H., 190 Duncan av., Jersey City
Brauer, Selig L., 234 Bergen av., Jersey City
Braunstein, Sigmund C., 424 13th st., W. New York
Braunstein, Wm. P., 1 Bellevue st., Weehawken
Brennock, Thos. McG., 3 Webster av., Jersey City
Brick, Geo. J., 43 Cottage st., Jersey City
Brophy, Francis X., 55 Gifford av., Jersey City
Brozdowski, John J., 554½ Jersey av., Jersey City
Bruder, Andrew J., 344 Fairmount av., Jersey City
Butler, Vincent deP., 33 Bentley av., Jersey City
Callery, Wm. T., 10 Columbia ter., Weehawken
Cannon, Edward A., 5360 Hudson Blvd., N. Bergen
Caridi, Salvatore, 465 Bergenline av., W. New York
Carr, Mary B., 1 Astor pl., Jersey City
Chapman, Ellis J., 203 Danforth av., Jersey City
Chayes, Sydney, 980 Ave. C, Bayonne
Christian, Henry A., 111 Fairview av., Jersey City
Cieri, Daniel S., 315 Central av., Union City
Clark, Chas. C., 461 New York av., Union City
Cobham, James L., 78 Brinkerhoff st., Jersey City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 714 Park av., Hoboken
Cohen, Samuel, 28 Duncan av., Jersey City
Cohen, Samuel A., 112 Mercer st., Jersey City
Comora, Herman C., 317 16th st., West New York
Connell, Emmet J., 2227 Boulevard, Jersey City

Connell, John N., 26 Carlton av., Jersey City
Connolly, Thos. W., 921 Bergen av., Jersey City
Conty, Anthony J., 318 48th st., Union City
Cosgrove, Samuel A., 254 Union st., Jersey City
Coughlin, John P., 160 Wegman Pkwy., Jersey City
Cracco, Frederick A., 51 Palisade av., Union City
Crowley, Leo F., 148 Belmont av., Jersey City
Culver, Geo. M., 25 Glenwood av., Jersey City
Culver, S. Herbert, 75 Magnolia av., Jersey City
Curtis, Grant P., 312 36th st., Union City
D'Acerno, Pellegrino A., 346 Palisade av., Union C'y
Daly, Edmund J., 921 Bergen av., Jersey City
Danielson, John J., 977 Bergen Trnpl., N. Bergen
Davey, Thomas N., 41 West 33rd st., Bayonne
Deary, Louis Edgar, 88 W. 39th st., Bayonne
DeFuccio, Charles P., 12 Duncan av., Jersey City
De Fusco, G. Thomas, 330 Newark av., Jersey City
DeMeritt, Chas. L., 1225 Bloomfield st., Hoboken
Dershimer, Frederick W., 546 Bergen av., Jer. City
Dexter, Harriet E. T., 903 Ave. C, Bayonne
Dillingham, Willis I., 431 15th st., West New York
Dodson, Louis W., 592 Jersey av., Jersey City
Dolganos, Moses, 268 Palisade av., Jersey City
Donnelly, Joseph P., 58 Kensington av., Jersey City
Donohoe, Lucius F., 140 W. 8th st., Bayonne
Doody, Wm. M., 19 Bentley av., Jersey City
Doran, Ralph J., 200 11th st., Hoboken
Doran, Wm. G., 921 Bergen av., Jersey City
Dougherty, Daniel D., 1006 Garden st., Hoboken
Draesel, Chas., 5681 Hudson Blvd., North Bergen
Driscoll, Raymond S., 919 Hudson Blvd., Bayonne
Duckett, Warren J., 21 Carlton av., Jersey City
Dukes, Howard R., 220 Kearny av., Kearny
Edgar, Joseph A., 71 Congress st., Jersey City
Edwards, Lena F., 358 Pacific av., Jersey City
Elsasser, Theodore H., 906 Park av., North Bergen
Enright, James G., 25 Kensington av., Jersey City
Evans, J. Lawrence, 893 Park av., Woodcliff
Facciolo, Francesco, 562 Hudson Blvd., Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Farr, John C., 75 10th st., Hoboken
Fattel, Henry C., 5508 Hudson Blvd., N. Bergen
Federer, John J., 69 Columbia ter., Weehawken
Feller, William, 283 Bergen av., Jersey City
Fellman, Morris, 118 Jewett av., Jersey City
Fenimore, Edward D., 3663 Hudson Blvd., Jer. City
Ferenzi, Louis J., 33 Edwards court, Bayonne
Ficke, Sylvia A., 884 Summit av., Jersey City
Fifer, William T., 746 Ave. C, Bayonne
Fineberg, Bernard J., 113 Bentley av., Jersey City
Fineberg, Jacob C., 50 Glenwood av., Jersey City
Finger, Frederick A., 938 Ave. C, Bayonne
Finke, Chas. H., 317 York st., Jersey City
Finn, Frederick A., 2729 Boulevard, Jersey City
Finn, Henry R. W., 84 Lembeck av., Jersey City
Flichtenfeld, Morris, 283 4th st., Jersey City
Flicker, David J., 342 Kearny av., Kearny
Frank, Morris S., 920 Ave. C, Bayonne
Frank, Nathan, 186 Bowers st., Jersey City
Franklin, I. Harold, 191 Palisade av., Jersey City
Freile, Wm., 25 Tonnele av., Jersey City
Frieman, Hyman, 744 Ave. C, Bayonne
Frundt, Oscar C., 92 Bartholdi av., Jersey City
Garibaldi, Louis J., 1016 Hudson st., Hoboken
Gerne, Timothy A., 972 Summit av., Jersey City
Ghee, Euclid P., 115 Claremont av., Jersey City
Ghee, Peter F., 734 Ocean av., Jersey City
Gille, Hugo, 149 Congress st., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
Gleeson, William J., 640 Bergen av., Jersey City
Godlin, David R., 610 36th st., N. Bergen
Goldowsky, Ira, 23 Warner av., Jersey City
Goldsmith, Alfred S., 240 29th st., N. Bergen
Goldstein, Joseph D., 2801 Hudson Blvd., Jer. City

Goldstone, Karl H., 16 18th st., West New York
Good, Richard B., 949 Park av., Union City
Goodrich, Steuart L., 812 Ave. C, Bayonne
Gorenberg, Harold, 54 Duncan av., Jersey City
Granelli, Humbert A., 213 Garden st., Hoboken
Greenberg, Philip, 1902 Hudson Blvd., Jersey City
Greene, Albert D., 195 Palisade av., Union City
Greene, Harry, 3285 Hudson Blvd., Jersey City
Grewal, Joseph S., 196 Broadway, Bayonne
Grieco, Emil H., 196 Broadway, Bayonne
Grossman, Rubin, 416 Boulevard, Bayonne
Gutmann, Erwin K., 229 Bowers st., Jersey City
Hall, Perry O., 254 Union st., Jersey City
Halligan, Earl J., 254 Montgomery st., Jersey City
Halperin, David, 590 Bergen av., Jersey City
Halpern, Sophia L., 271 Palisade av., Union City
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. Ameroy, 777 Boulevard E., Weehawken
Harvey, John W., 818 Ave. C, Bayonne
Hasking, Arthur P., 318 Montgomery st., Jersey City
Heilbrunn, Julius, 135 Belmont av., Jersey City
Hekimian, Jacob H., 468 Palisade av., Weehawken
Herradora-Ubeda, Juan R., 2787 Boulevard, Jer. C'y
Higgins, Gerald L., 94 Lembeck av., Jersey City
Higgins, John T., 145 Highland av., Jersey City
Higgins, Thos. A., 2616 Hudson Blvd., Jersey City
Hill, Wm. F., 104 Grand st., Jersey City
Hillel, Joseph, 1394 Park av., Hudson Heights
Hollywood, Jas. L., 1818 Hudson Blvd., Jersey City
Hoops, Harold J., 2203 Boulevard, Jersey City
Howeth, John L., 14 Duncan av., Jersey City
Imhoff, John G., 55 Lincoln st., Jersey City
Introcaso, Dominick A., 45 Crescent av., Jersey City
Jacks, Oscar, 476 Mercer st., Jersey City
Jaffe, Benjamin, 566 Bergen av., Jersey City
Jaffe, Herman M., 2600 Boulevard, Jersey City
Jaffin, Abraham E., 41 Emory st., Jersey City
Jaques, J. Eugenia, 74 Wavery st., Jersey City
Jentz, John H., 63 Sherman pl., Jersey City
Jones, Clement M., 438 Boulevard, Bayonne
Jones, John M., Valley rd., R. F. D., Oakland
Joseph Benj. M., 2771 Boulevard, Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Kaplan, Herman B., 324 44th st., Union City
Katz, Jacob D., 115 Belmont av., Jersey City
Kearney, John V., 331 34th st., North Bergen
Keegan, Thomas D., 83 Gifford av., Jersey City
Keeney, James C., 1201 Park av., Hoboken
Kelley, Chas. B., 921 Bergen av., Jersey City
Kelly, Bernard S., 1954 Boulevard, Jersey City
Kelly, Harry R. J., 311A Brown st., Union City
Kerdasha, Geo. S., 131 31st st., North Bergen
Kiely, Eugene M., 800 Hudson st., Hoboken
Kimmel, M. Leonard, 142 Manhattan av., Jersey C'y
Klaus, Henry, 435 Palisade av., Union City
Knopf, Edward, 343 Fairmount av., Jersey City
Kolb, John M., 725 10th st., Union City
Kooperman, Barnett, 321 16th st., West New York
Kooperstein, Samuel I., 395 Ogden av., Jersey City
Koppel, Joseph A., 921 Bergen av., Jersey City
Kraemer, Samuel H., 309 Baldwin av., Jersey City
Kraut, Arthur M., 2801 Boulevard, Jersey City
Kresch, Philip, 42 W. 22nd st., Bayonne
Kuhlmann, Alvin E., 527 37th st., Union City
Kun, Bertram, 135 Belmont av., Jersey City
Landshof, Chas. A., 50 Glenwood av., Jersey City
Lane, Thomas F., 155 Garrison av., Jersey City
Lange, Louis C., 50 Clifton ter., Weehawken
Largay, Arthur O., 937 Ave. C, Bayonne
Larkey, Chas. J., 700 Ave. C, Bayonne
Lawsing, George C., 443 22nd st., West New York
Lefkowitz, Jacob H., 445 20th st., West New York
Leir, J. Krevin, 9 Garrison av., Jersey City
Lemmerz, Theodore H., 141 Magnolia av., Jersey C'y

- Levine, G. Irving, 2017 Hudson Blvd., Jersey City
 Linden, Mortimer H., 45 Clendenny av., Jersey City
 Lindroth, Lawrence V., 620 Pavonia av., Jersey City
 Lipshutz, Benjamin, 13 West 22nd st., Bayonne
 Lipshutz, Chas., 804 Ave. C, Bayonne
 Little, Alonzo W., 120 Arlington av., Jersey City
 Lobban, Robert B., 2595 Boulevard, Jersey City
 Londrigan, Jos. F., 535 Washington st., Hoboken
 Londrigan, Joseph F., II, 832 Wash'gton st., Hobok'n
 Long, Miles T., 2150 Boulevard, Jersey City
 Loori, Wm. A., 549 Pavonia av., Jersey City
 Luczynski, Edw. W., 28 E. 22nd st., Bayonne
 Luippold, Eugene J., 85 Columbia ter., Weehawken
 Lupin, Edward E., 727 Ave. C, Bayonne
 Lynch, Roland J., Mental Disease Hosp., Secaucus
 Lynn, Irving I., 2252 Boulevard, Jersey City
 Mackin, John J., 596 Bergen av., Jersey City
 Madaras, John S., 870 Ave. C, Bayonne
 Madden, Wm. L., 83 Gifford av., Jersey City
 Madison, Lewis K., 358 Pacific av., Jersey City
 Mango, Concetta G., 1 31st st., North Bergen
 Mangone, Geo. F., 171 Palisade av., Union City
 Maras, Peter E., 80 Tonnele av., Jersey City
 Markowitz, Benj. B., 2157 Boulevard, Jersey City
 Markowitz, Irwin B., 2157 Boulevard, Jersey City
 Marks, David M., 298 4th st., Jersey City
 Marshall, Frank A., 440 Palisade av., Weehawken
 Mastromonaco, Joseph D., 35 W. 34th st., Bayonne
 Mathesheimer, Jacob L., 280 Old Bergen rd., Jer. C'y
 Mathews, Wm. J., 938 Hudson st., Hoboken
 Matturri, Dominick A., 174 Clinton av., Jersey City
 Maturi, Vincenzo E., 814 Hudson Blvd., Bayonne
 Maver, Wm. W., 532 Bergen av., Jersey City
 McDede, J. Searle, 215 Ege Ave., Jersey City
 McDonald, Frank R., 37 Monticello av., Jersey City
 McLean, Herbert E., 92 Fairview av., Jersey City
 McLean, Hugh A., 414 17th st., West New York
 McLoughlin, Frank J., 558 Jersey av., Jersey City
 McNenney, Claudio E., 113 Fairview av., Jersey City
 Meehan, George E., 117 Mercer st., Jersey City
 Meltsner, Louis, 904 Hudson st., Hoboken
 Meltzer, Louis, 32 W. 33rd st., Bayonne
 Mendelsohn, Lewis, 272 Montgomery st., Jersey City
 Mersheimer, Christian H., 15 Reservoir av., Jer. C'y
 Meyer, Wm., 436 New York av., Union City
 Meyerson, Noah, 428 15th st., West New York
 Mickewich, Stephen A., 650 Ave. C, Bayonne
 Miller, Max H., 311 16th st., West New York
 Milnis, Bernard, 100 30th st., Woodcliff
 Monaghan, Wm. J., Hudson Co. Gen'l Hosp., Sec'c's
 Morley, Grace C., 64 Clifton ter., Weehawken
 Morris, David G., 11 W. 26th st., Bayonne
 Muccia, John J., 7 Tonnele av., Jersey City
 Mueller, George H., 102 Summit av., Jersey City
 Mulvihill, William J., 275 Hudson Blvd., Bayonne
 Murphy, Edward A., 1 Britton st., Jersey City
 Murphy, James M., 2757 Boulevard, Jersey City
 Murphy, Leo J., 374 West st., Union City
 Murphy, Patrick H. W., 27 Jefferson av., Jer. City
 Murray, Jos. A., 765 Ave. C, Bayonne
 Mustermann, Otto H., 303 48th st., Union City
 Muttart, George W., 702 Ocean av., Jersey City
 Mutter, Alfred A., 75 Beech st., Kearny
 Nafash, Shafeek, 86 Palisade av., Union City
 Nalitt, David I., 28 W. 33rd st., Bayonne
 Napoli, Joseph D., 575 Summit av., Union City
 Newman, Abraham J., 132 Manhattan av., Jer. City
 Nicholson, Frank P., 895 Summit av., Jersey City
 Norton, James F., 58 Kensington av., Jersey City
 Norwich, Louis E., 355 Ave. C, Bayonne
 Nuse, Edward F., 550½ Jersey av., Jersey City
 Ockene, Abraham, 495 Palisade av., Union City
 O'Connor, John J., 434 New York av., Union City
 O'Gorman, Michael W., 895 Bergen av., Jersey City
 O'Grady, Benson J., 931 Washington st., Hoboken
 O'Hanlon, George, Medical Centre, Jersey City
 Older, Benj., 435 New York av., Union City
 Olpp, Arch. E., 318 Bergenline av., Union City
 O'Neill, John H., 270 Montgomery st., Jersey City
 Opdyke, Levings A., 55 Clinton av., Jersey City
 Ortolano, Jas. J., 159 First st., Hoboken
 O'Shea, John J., 438 Palisade av., Weehawken
 Oshrin, Henry, 750 Park av., West New York
 O'Sullivan, John R., 33 Hamilton av., Kearny
 Ovens, Ritchie C., 675 Bergen av., Jersey City
 Owen, Logan S., 938 Hudson st., Hoboken
 Pacicco, Michele, 376 Monmouth st., Jersey City
 Pagliughi, John J., 401 18th st., Union City
 Papalia, Joseph A., 308-8th st., Union City
 Pearlstein, Frank, 325 - 16th st., West New York
 Pearson, J. Gerald, 817 Washington st., Hoboken
 Pellarin, John D., 493 New York av., Union City
 Penchansky, Samuel J., 847 Ave. C, Bayonne
 Pentel, Louis S., 307 16th st., West New York
 Perkel, Louis L., 2801 Hudson Blvd., Jersey City
 Perlberg, Harry J., 921 Bergen av., Jersey City
 Perrone, Arthur F., 415 - 16th st., West New York
 Peters, Edgar A. P., 394 Bergen av., Jersey City
 Peterson, Chas. A., 921 Washington st., Hoboken
 Piltz, Geo. F., 153 - 25th st., Guttenberg
 Pindar, Frederick S., 960 Park av., North Bergen
 Pinkerton, Wm. A., 854 Ave. C, Bayonne
 Piskorski, Abdon V., 604 Jersey av., Jersey City
 Plavin, Nathan J., 5460 Hudson Blvd., No. Bergen
 Pollak, Berthold S., 100 Clifton pl., Jersey City
 Pontery, Herbert B., 89 Bowers st., Jersey City
 Posnock, Samuel M., 677 Ave. C, Bayonne
 Potter, Benjamin P., Hud. Co. Tub. San., Jer. City
 Povalski, Alex. W. T., 1925 Boulevard, Jersey City
 Purdy, Chas. H., 35 Highland av., Jersey City
 Pyle, Louis A., 89 Fairview av., Jersey City
 Pyle, Wallace B., 15 Exchange pl., Jersey City
 Quigley, Frederic J., 543 - 45th st., Union City
 Quinn, John J., 921 Bergen av., Jersey City
 *Rector, Joseph M., 681 Bergen av., Jersey City
 Reingold, Alexander, 221 Garden st., Hoboken
 Reitnauer, John S., 518 - 44th st., Union City
 Rieck, Walter R., 379 Kearny av., Kearny
 Rieman, Aloysius P., 3566 Boulevard, Jersey City
 Riese, Jacob A., 636 Palisade av., West New York
 Robbins, Henry B., 144 Mercer st., Jersey City
 Roberts, Edgar W., 760 Palisade av., W. New York
 Rosecrans, James H., 826 Hudson st., Hoboken
 Rosenberg, Albert B., 69 Myrtle av., Plainfield
 Rosenberg, Jacob, 692 Bergen av., Jersey City
 Rosenstein, Jacob L., 568 Bergen av., Jersey City
 Rowe, Norman L., 828 Grand st., Jersey City
 Rubenstein, Eli, 79 West 32nd st., Bayonne
 Rundlett, Emilie V., 79 Prospect st., Jersey City
 Ruoff, Andrew C., 494 New York av., Union City
 Russell, David L., 690 Bergen av., Jersey City
 Sacco, Anthony G., 440 New York av., Union City
 Sachs, Wilbert, 921 Bergen av., Jersey City
 Santangelo, Stephen, 461 Jersey av., Jersey City
 Santosky, Benj. B., 143 Bergen av., Jersey City
 Saradarian, Albert V., 481 New York av., Union City
 Schenker, Benjamin N., 246 - 5th st., Jersey City
 Schept, Samuel S., 523 - 37th st., Union City
 Schlein, August, 707 Park av., Hoboken
 Schneider, Louis A., 412 - 17th st., West New York
 Schuchner, Wm. F., 550½ Jersey av., Jersey City
 Schuck, Traugott J., 58 - 9th st., Hoboken
 Schulman, Abraham S., 4638 Boulevard, Union City
 Schwarz, B. T. D., 2787 Hudson Blvd., Jersey City
 Schwarz, Henry J., 5560 Hudson Blvd., N. Bergen
 Scott, Samuel G., 141 Bergen av., Jersey City
 Selinger, Samuel, 413 - 16th st., West New York
 Sexsmith, George H., 719 Ave. C, Bayonne

Shapiro, Maurice, 750 Ave. C, Bayonne
Shapiro, Saul J., 192 Palisade av., Union City
Sheeran, Vincent J., 269 Jewett av., Jersey City
Shook, B. E., 284 Bergen av., Jersey City
Shulman, Nathan L., 538 - 45th st., Union City
Siegel, Sidney L., 227 N. Second st., Millville
Siegler, Julius, 646 Bergen av., Jersey City
Silich, Robert L., 27 - 4th st., Weehawken
Simeone, Peter A., 555 - 38th st., Union City
Simpson, David B., 9 E. 35th, st., Bayonne
Singer, Sina S., 3443 Hudson Blvd., Jersey City
Smith, Alex. L., 2672 Boulevard, Jersey City
Smith, Arthur B. R., 13 Fairmount ter., Jersey City
Snyder, John E., 1023 Garden st., Hoboken
Snyder, Wm. J., 74 Columbia ter., Weehawken
Spano, Frank, 320 - 47th st., Union City
Spath, George B., 722 Hudson st., Hoboken
Spence, Henry, 2540 Hudson Blvd., Jersey City
Spohn, Eugene L., 921 Bergen av., Jersey City
Sprague, Seth B., 301 York st., Jersey City
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robert H., 3637 Boulevard, Jersey City
Stokes, Anthony T., 319 First st., Secaucus
Stout, John P., 165 Jewett av., Jersey City
Street, Daniel B., 27 Woodlawn av., Jersey City
Stuart, William C., 518 Hudson st., Hoboken
Sullivan, James A., 668 Jersey av., Jersey City
Sulouff, S. Henry, 662 Newark av., Jersey City
Sussman, Harold, 541 - 44th st., Union City
Sweeney, William J., 68 Clifton ter., Weehawken
Swiney, Juliana C., 325 Avenue C, Bayonne
Swiney, Merrill A., 325 Avenue C, Bayonne
Taft, Herman L., 26 - 4th st., Weehawken
Talty, John C., 935 Washington st., Hoboken
Tataryan, Hovsep H., 422 New York av., Union City
Temes, Julius H., 293 Ege av., Jersey City
Thomas, Ralph B., 793 Montgomery st., Jersey City
Tidwell, Harold F., 229 - 16th st., West New York
Timlin, James W., 66 Beech st., Arlington
Tomaiuolo, Michele, 71 - 32nd st., North Bergen
Tyndall, Hugh H., 83 Highwood ter., Weehawken

Urevitz, Abraham, 495 New York av., Union City
Varriano, John L., 3263 Hudson Blvd., Jersey City
Visconti, Jos. A., 711 Garden st., Hoboken
Vostrosablin, Nicholas A., 121 Grand st., Jersey City
Vreeland, William N., 32 Bergen av., Jersey City
Wallack, Eli A., 333 Fairmount av., Jersey City
Walscheid, Arthur J., 440 - 38th st., Union City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2786 Boulevard, Jersey City
Weber, Walter D., 305 - 23rd st., Union City
Wechsler, Joseph, 3342 Hudson Blvd., Jersey City
Weiss, Abram, 456 Palisade av., Weehawken
Weiss, Morris J., 734 Ave. C, Bayonne
Welcher, Howard A., 5436 Hudson Blvd., N. Bergen
Wheeler, James A., 85 Van Reyden st., Jersey City
White, Hugh M., 901 Summit av., Jersey City
White, Thomas J., 50 Glenwood av., Jersey City
Wilcox, Frank A., 329 - 16th st., West New York
Williamson, Wm. L., 22 W. 22nd st., Bayonne
Woelfle, Henry E., 907 Summit av., Jersey City
Wolbert, Charles M., 691 Palisade av., Cliffside Pk.
Woodruff, Stanley R., 16 Enos pl. Jersey City
Yeaton, Wm. L., Jr., 204 - 11th st., Hoboken
Yudkoff, Wm., 403 Boulevard, Bayonne
Zenneck, Junius F., 17 Fourth st., Weehawken
Zitani, Alfred M., 937 Washington st., Hoboken

Honorary Members

Connell, John, 977 Summit av., Jersey City
Hardenberg, Daniel S., 347 Communipaw av., J. City
Miner, Donald, 96 Gifford av., Jersey City
Oestmann, August W., 932 Summit av., Jersey City
Vreeland, Hamilton, 232 S. Irving st., Ridgewood
Wilkinson, George, 144 Old Bergen rd., Jersey City

Transferred

Disler, Louis, from Union County Medical Society
Sandler, Samuel A., to Bergen County Med. Society

Number of Active Members and basis of representation, 432, March 15, 1939.

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October. April being the Annual Meeting.

Active Members

Apgar, Francis A., Oldwick
Baker, Philip W., High Bridge
Boothby, I. Roland, Clinton
Boyer, Charles G., Annandale
Christensen, Alex. H., Lebanon
Clark, Frank G., White House Station
Closson, Edward W., 2 Main st., Lambertville
Coleman, Austin H., Clinton
Decker, Frederick H., 32 5th st., Frenchtown
English, Samuel B., Glen Gardner
Fuhrmann, Barclay S., 10 Main st., Flemington
Fulper, Theodore B., Hampton
Garfinkel, Abraham, 30 Broad st., Flemington
Germain, Raymond J., High Bridge
Gross, Max, N. J. Sana. for T. B. Dis., Glen Gardner
Hamilton, Lloyd A., 46 York st., Lambertville
Hell, Alva A., Milford
Jenkins, Arthur M., 701 Harrison st., Frenchtown
Knox, Howard A., New Hampton
Lane, Edgar W., 46 Main st., Bloomsbury
Leaver, Morris H., Quakertown

McCorkle, William E., Ringoes
Mullins, Roy L., 305 Harrison st., Frenchtown
Pearson, Theodore A., Whitehouse Station
Smith, Ivan B., Pittstown
Thomas, Floyd A., 97 Main st., Flemington
Tompkins, Grenelle B., 52 Broad st., Flemington

Honorary Members

Morrison, J. Bennett, Oceanside, California
Scammell, Frank G., Trenton
Sommer, George N. J., Sr., Trenton

Resigned

Judd, A. R.

Transferred

Gramsch, A. Louis, to Bergen County Med. Society
Harner, R. M., to Canton, Ohio
Pearson, T. A., to Somerset County Med. Society

Number of Active Members and basis of representation, 27, March 15, 1939.

MERCER COUNTY (11)

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 8:30 p. m., in the Trenton Country Club. Annual Meeting in December. Annual Banquet in November.

Active Members

Abey, W. J. H., 21 E. Delaware av., Pennington
Ackley, David B., 21 N. Clinton av., Trenton
Anthony, David W., 201 Witherspoon st., Princeton
Applegate, Edw. T. R., 1125 Greenwood av., Trenton
Applestein, Robert, 568 E. State st., Trenton
Aronis, Harry R., 239 E. Hanover st., Trenton
Ashley, Harmon H., 192 W. State st., Trenton
Barrows, Arthur M., 440 Hamilton av., Trenton
Barry, Rolla G., 908 W. State st., Trenton
Bayne, J. K., 12 Princeton av., Princeton
Beairst, Everett B., 178 W. State st., Trenton
Belfer, Jacob J., 1235 Chambers st., Trenton
Belford, Ralph J., 90 Nassau st., Princeton
Bellis, Horace D., 437 E. State st., Trenton
Belting, Arthur W., 836 West State st., Trenton
Berger, Harry, 921 S. Clinton av., Trenton
Berman, Jacob J., 409 Market st., Trenton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 190 W. State st., Trenton
Blum, Joseph M., 128 Mill st., Trenton
Borrella, Dominic D., 476 Hamilton av., Trenton
Buckley, Richard T., Jr., Peddie Sch., Hightstown
Burbidge, J. Raymond, McCosh Infirm., Princeton
Burns, Joseph R., 46 S. Olden av., Trenton
Burroughs, Edmund W., 701 W. State st., Trenton
Byer, M. Yale, 827 E. State st., Trenton
Carabelli, A. Albert, 306 Hamilton av., Trenton
Carroll, C. Walter, 117 Centre st., Trenton
Carroll, William V., 211 Academy st., Trenton
Cella, Charles F., 335 Hamilton av., Trenton
Chesner, Wm. A., 1111 Hamilton av., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Clark, Alice L., 206 W. State st., Trenton
Clark, Charles E., New Jersey State Hosp., Trenton
Cohan, Charles C., 217 W. Hanover st., Trenton
Cohen, Herman, 1301 Hamilton av., Trenton
Cohen, Wm., 1007 Greenwood av., Trenton
Collier, Wm. S., 1000 S. Broad st., Trenton
Collins, Henry J., 1160 Hamilton av., Trenton

Comfort, John B., 50 S. Clinton av., Trenton
Connelly, John A., 212 W. State st., Trenton
Corio, Geo. A., 307 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
Cotton, Henry A., Jr., 192 W. State st., Trenton
Cottone, Rosario J., 683 Princeton av., Trenton
Cowlbeck, Harry D., 224 W. State st., Trenton
Cox, Harold C., 208 Stockton st., Hightstown
Cunningham, Joel B., 31 N. Main st., Pennington
D'Arcy, Walter E., 545 E. State st., Trenton
Davenport, Irwin P., 194 W. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
Davis, John E., Jr., N. J. State Hospital, Trenton
Davison, Royden W., 205 W. State st., Trenton
Dean, Guy K., Jr., Plainsboro rd., Princeton
Deitz, Joseph R., 320 Centre st., Trenton
Dembinski, T. Henry, 1238 S. Clinton av., Trenton
Denelsbeck, J. Otis, 878 E. State st., Trenton
Dimun, John T., 960 S. Broad st., Trenton
Doranz, Harold K., 491 Centre st., Trenton
Drezner, Henry L., 507 S. Warren st., Trenton
Eames, Wm. N., 1871 Pennington rd., Trenton
Elias, Elmer J., 474 Greenwood av., Trenton
Engelhart, Ferdinand K., 701 Stuyves't av., Trenton
Epstein, Rubie, 606 Perry st., Trenton
Ernest, Richard B., 240 W. State st., Trenton
Fabian, Paul L., 520 Princeton av., Trenton
Farmer, Walter D., 28 S. Main st., Allentown
Fee, Elam K., Main st., Lawrenceville
Fell, Alton S., Municipal Hospital, Trenton
Fessler, A. James, 1544 S. Broad st., Trenton
Fine, Sydney G., N. J. State Hospital, Trenton
Finegan, Paul J., 200 W. State st., Trenton
Finkle, Lester J., 225 Perry st., Trenton
Fiorello, Joseph R., 706 Princeton av., Trenton
Fluck, David A., 548 W. State st., Trenton
Forer, Robert, 247 Centre st., Trenton
Franzoni, Andrew E., 938 Brunswick av., Trenton
Friedman, Max, 493 Chambers st., Trenton
Friedman Meyer H., 526 N. Clinton av., Trenton

Friedmann, Leonard L., 484 Princeton av., Trenton
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Goldberg, Ben M., 1156 E. State st., Trenton
Goldman, Leo L., 325 Market st., Trenton
Gordon, Clark H., 808 E. State st., Trenton
Graham, Ernest E., 4273 S. Broad st., Yardville
Guglielmelli, Angelo D., 449 Hamilton av., Trenton
Guidotti, Frank P., 1022 Greenwood av., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
Haines, Evelyn M., 1022 Greenwood av., Trenton
Hale, Henry E., Jr., Battlefield Farm, Princeton
Hammell, Frank M., 137 S. Main st., Allentown
Haney, John J., 850 Hamilton av., Trenton
Harman, James R., 824 W. State st., Trenton
Harman, Wm. J., 740 W. State st., Trenton
Hess, George A., River road, Titusville
Hiden, Jos. C., 199 Nassau st., Princeton
Hirschfield, Bernard A., 438 Hamilton av., Trenton
Holland, John A., 1219 W. State st., Trenton
Horhovit, George I., 324 S. Broad st., Trenton
Hunter, Floyd D., 3620 Nottingham Way, Ham. Sq.
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., 55 Mercer st., Hamilton Sq.
Iams, Samuel H., 245 Library pl., Princeton
Ireland, Allen G., 28 W. State st., Trenton
Ivins, Wm. C., 214 E. Hanover st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Kachdorian, Vartan, 930 Brunswick av., Trenton
Klempner, Paul, 414 Market st., Trenton
Kohn, Joseph J., 207 Calhoun st., Trenton
Kondor, Joseph S., 978 S. Broad st., Trenton
Koplin, Nathaniel H., 142 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
Lapin, Louis P., 15 Crosswicks st., Bordentown
Lapin, Samuel B., 542 W. State st., Trenton
Larsson, Evert A., N. J. State Hospital, Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lavine, Sidney B., 134 W. State st., Trenton
Lettiere, Anthony J., 425 E. State st., Trenton
Levin, Louis, 651 W. State st., Trenton
Levy, Irvin, 154 W. State st., Trenton
Little, William R., 493 W. State st., Trenton
MacDermid, Lynden, 506 Farnsworth av., Bordent'w
MacFarland, Burr W., 419 W. State st., Trenton
Magee, Harold S., New Jersey State Hosp., Trenton
Majeski, Henry J., 935 Brunswick av., Trenton
McCandliss, Wm. K., State Hospital, Trenton
McCullough, John H., 523 E. State st., Trenton
McGuigan, Francis A., 212 N. Warren st., Trenton
Means, Paul B., State Hospital, Trenton
Meehan, Marjorie C., 24 Murray pl., Princeton
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, Gerald H., N. Main st., Cranbury
Miller, Samuel R., 407 S. Main st., Pennington
Mitchell, Chas. H., 1100 W. State st., Trenton
Mitskas, Theo. V. J., 704 Greenwood av., Trenton
Moriconi, Albert F., 438 Hamilton av., Trenton
Munro, Jeannette, 2 Queenston pl., Princeton
Murphy, James A., 142 N. Clinton av., Trenton
Murto, Thomas V., 532 W. State st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
North, Harry R., 160 W. State st., Trenton
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, Horace N., 72 N. Clinton av., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st., Trenton
Pierson, Carl L., 178 W. State st., Trenton
Pierson, Joseph R., 10 E. Broad st., Hopewell
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 198 W. State st., Trenton
Poyas, Morton L., 306 W. State st., Trenton
Proctor, Francis E., 1245 Greenwood av., Trenton
Purcell, Ernest F., 800 Stuyvesant av., Trenton
Ragany, Joseph, 966 S. Broad st., Trenton

Rainey, Willard G., 34 Bayard lane, Princeton
Rampona, Joseph M., 118 Nassau st., Princeton
Rapp, Robert F., 302 Main st., Hightstown
Reisinger, Paul B., 369 W. State st., Trenton
Rita, James J., 235 S. Clinton av., Trenton
Rogers, Laurence H., Municipal Hospital, Trenton
Rowan, Henry M., 224 W. State st., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scammell, Frank G., 40 S. Clinton av., Trenton
Scasserra, Benedict B., 163 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Schroeder, Henry J. L., Hotel Windsor, Trenton
Seely, Roy B., 78 N. Clinton av., Trenton
Seitzick-Robbins, H. E., 733 Hamilton av., Trenton
Sekerak, Albert J., 984 S. Broad st., Trenton
Shear, Maurice M., 1158 E. State st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Siemion, Theophilis R., 1005 Brunswick av., Trenton
Sill, John B., 942 W. State st., Trenton
Silver, E. Drew, 136 Stockton st., Hightstown
Silver, George A., 242 Stockton st., Hightstown
Sinton, John Y., Imlaystown
Slack, Clarence J., 230 W. State st., Trenton
Smith, Houghton C., 1063 S. Clinton av., Trenton
Smith, Paul E., State Hospital, Trenton
Smith, W. Henley, 126 W. State st., Trenton
Snegireff, Leonid S., 14 Waverly pl., Trenton
Sommer, Geo. N. J., 120 W. State st., Trenton
Sommer, Geo. N. J., Jr., 120 W. State st., Trenton
Spradley, Jeems B., N. J. State Hospital, Trenton
Stein, Louis A., 226 W. State st., Trenton
Stone, Robert G., State Hospital, Trenton
Storaci, Frank S., 703 Hamilton av., Trenton
Summers, Alfred D., 180 Nassau st., Princeton
Sutnick, Theodore B., 1018 S. Broad st., Trenton
Swern, Nathan, 399 W. State st., Trenton
Swertfeger, Herbert W., 106 W. Broad st., Hopewell
Taylor, Walter A., 450 Rutherford av., Trenton
Tomec, Otto C., 407 W. State st., Trenton
Treiber, Benjamin A., 219 W. State st., Trenton
Turner, Irvine F. P., 224 W. State st., Trenton
Urbanak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Joseph S., 45 Princeton av., Princeton
Vol-Tretter, Marta, 302 W. State st., Trenton
Waldron, Edward L., 126 W. State st., Trenton
Walsh, Thomas J., 514 Greenwood av., Trenton
Warter, Peter J., 626 W. State st., Trenton
Waters, Chas. H., 928 W. State st., Trenton
Watov, Samuel E., 603 Beatty st., Trenton
Watson, Fred'k S., 238 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, Bernard R., 834 Stuyvesant av., Trenton
West, Edgar L., 443 E. State st., Trenton
Wiesler, Howard M., 128 Third st., Trenton
Wikoff, John L., 799 Pennington av., Trenton
Wilbur, William L., 156 Stockton st., Hightstown
Wilkes, LeRoy A., 143 E. State st., Trenton
Williams, Geo. W., 217 N. Warren st., Trenton
Williams, Harry D., 527 E. State st., Trenton
Wilner, Arthur S., 205 Market st., Trenton
Wittenborn, W. F. J., 1613 Brunswick av., Trenton
Wright, Howard E., 173 Nassau st., Princeton
Yaeger, Leslie A., 470 Hamilton av., Trenton
Yazujian, Dikran M., 562 E. State st., Trenton
York, Wilbur H., 87 Battle rd., Princeton
Zandt, Frederic B., 16 Mercer st., Hamilton Sq.
Zentner, Maurice R., 1271 Hamilton av., Trenton
Zimskind, Joshua N., 210 W. State st., Trenton

Associate Members

Abrams, Henry, 195 Nassau st., Princeton
Colavita, James J., 433 Princeton av., Trenton
Communi, Frank F., 217 Hamilton av., Trenton

Dodge, James T., 1819 S. Broad st., Trenton
 Fritz, John F., Jr., 1129 Hamilton av., Trenton
 Hafetz, M. Morris, 114 Centre st., Trenton
 Harrop, George A., 33 Cleveland lane, Princeton
 James, J. Thomas, 57 Wiggins st., Princeton
 Janoff, Henry, 626 Perry st., Trenton
 Johnson, John F., 203 Abernethy dr., Trenton
 Kohn, Ralph B., 207 Calhoun st., Trenton
 Koplin, A. Herman, 1239 Greenwood av., Trenton
 Lynch, Donald C., 178 W. State st., Trenton
 Minschwaner, Geo. G., Jr., 954 Greenw'd av., Trenton
 Mountford, William E., 215 N. Warren st., Trenton
 Nicolais, Michael A., 346 Farnsworth av., Bordent'n
 O'Neill, Joseph F., Jr., 41 E. Broad st., Hopewell
 Pittman, Allen R., N. J. State Hospital, Trenton
 Sackin, Stanley, 1009 Hamilton Ave., Trenton
 Stabile, John A., Grand av., W. Trenton
 Steel, John M., N. J., State Hospital, Trenton

Tenney, Luman H., 177 Prospect av., Princeton
 Wilson, Richard P., 497 Pennington av., Trenton

Honorary Members

Bruyere, John, Trenton
 Pierson, Theodore A., Hopewell

Resigned

Allman, S. J.
 Mras, J. M.
 Sharbaugh, G. B.
 Staciva, S. J.

Transferred

Martin, Elizabeth L., to Warren County Med. So.

Number of Active Members and basis of representation, 223, March 15, 1939.

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December

Active Members

Anderson, John F., 195 College av., New Brunswick
 Avery, Philip S., Middlesex Gen. Hosp., N. Brunswick
 Bassett, Lavern C., 320 New Market rd., Dunellen
 Belafsky, Henry A., 150 Green st., Woodbridge
 Berkow, Samuel G., 138 Market st., Perth Amboy
 Breslow, Samuel, 157 Market st., Perth Amboy
 Brody, Morton S., 75 Livingston av., N. Brunswick
 Brown, Fred. L., 67 Livingston av., New Brunswick
 Burnett, Chas. B., 109 Main st., South River
 Calvin, Charles H., 80 Commerce st., Perth Amboy
 Clarke, Francis M., 116 New st., New Brunswick
 Cohen, Nathan B., 232 State st., Perth Amboy
 Cooper, Irving J., 116 Livingston av., N. Brunswick
 Copleman, H. B., 50 Livingston av., N. Brunswick
 Cottrell, Judson G., 159 Market st., Perth Amboy
 Csema, Emery J., 151 Somerset st., New Brunswick
 Degenhardt, Ira H., 51 Livingston av., N. Brunswick
 Dieker, Howard E., 78 Main st., South River
 Downing, Perley E., Sedgwick av., Jamesburg
 Downs Louis S., 141 Roosevelt av., Carteret
 East, Isaac C., State Home for Boys, Jamesburg
 Fagan, Jas. L., 51 Bayard st., New Brunswick
 Fanelli, Antonio, 471 Laurie st., Perth Amboy
 Faulkingham, Ralph J., 61 Livingston av., N. Br'w'k
 Feher, Ladislav A. M., 177 Somerset st., New Bruns.
 Fine, Hyman P., 151 Market st., Perth Amboy
 Fishkoff, Alexander H., 132 Market st. P'th Amboy
 Fith'an, Geo. W., 266 High st., Perth Amboy
 Forney, Norman N., Sr., 96 N. Main st., Milltown
 Gauzza, Valentine P., 505 New Brunswick av., Fords
 Gessner, Gerard R., St. Peter's Hosp., New Br'ns'k
 Goldberg, Harry C., 135 Market st., Perth Amboy
 Grieve, James, 88 Market st., Perth Amboy
 Gurshman, Sol, 280 Amboy av., Metuchen
 Gutowski, Jos. M., 433 Brace av., Perth Amboy
 Haight, Harry W., 118 Raritan av., New Brunswick
 Hanson, Edward K., 684 Amboy av., Fords
 Hauber, Eugene A., 6 Quaid st., Sayreville
 Haywood, Henry, 49 Paterson st., New Brunswick
 Henry, Frank C., Jr., 214 Smith st., Perth Amboy
 Hilker, Geo. F., 258 Maple st., Perth Amboy
 Hinton, Samuel H., 121 Main st., Sayreville
 Hoffman, Florentine M., 91 Bayard st., New Bruns.
 Howley, Bartholomew M., 419 George st., N'wBrns.
 Hunt, Melvin M., 140 Jackson st., South River
 Hutner, Cyril I., 134 Grove av., Woodbridge
 Jablonski, John J., 100 Main st., Sayreville

Jacobson, Murray B., 241 State st., Perth Amboy
 Karshmer, Nathan, 92 Carroll pl., New Brunswick
 Kemeny, Imre, 48 Pulaski av., Carteret
 Kinney, Seldon T., 250 Main st., South Amboy
 Kleiber, Estelle E., 139 New st., New Brunswick
 Klein, Alexander, 328 High st., Perth Amboy
 Klein, William, 85 Bayard st., New Brunswick
 Kler, Joseph H., 77 Livingston av., New Brunswick
 Koelsch, Frederic J., 14 Kirkpatrick st., N'wBr'ns'k
 Kovarsky, Albert E., 110 Market st., Perth Amboy
 Kramer, Samuel E., 121 Market st., Perth Amboy
 Lazow, S. Manlius, 199 Main st., Matawan
 Leonard, Geo. F., 63 N. 5th av., Highland Park
 Lief, Lawrence H., 41 Railroad av., Jamesburg
 London, William, 255 State st., Perth Amboy
 Long, Pauline A., 22 Livingston av., New Brunswick
 Lund, John L., 267 High st., Perth Amboy
 MacDowall, John L., 113 Market st., Perth Amboy
 Mann, Benjamin, 468 Brace av., Perth Amboy
 Mann, Jacob J., 255 State st., Perth Amboy
 Margaretten, Edward I., 263 High st., Perth Amboy
 Mark, Joseph S., 102 Green st., Woodbridge
 Marvin, Dorothy H., 51 Livingston av., New Bruns.
 Massey, J. Bruce, 20 Codwise av., New Brunswick
 McCormick, Wm. H., Jr., 266 Market st., P. Amboy
 McGovern, John F., Jr., 24 Livingston av., N'wBr'k
 McKiernan, Robt. L., 97 Bayard st., New Brunswick
 McKinstry, John W., Railroad av., Jamesburg
 Meacham, Eugene A., 112 N. Stevens av., S. Amboy
 Meinzer, Martin S., 147 Market st., Perth Amboy
 Miller, Theodore J., 527 New Brunswick av., Fords
 Morris, Carlyle, Spring st. & Lake av., Metuchen
 Nafey, Herbert W., 51 Livingston av., NewBr'ns'w'k
 Naulty, Chas. W., Jr., 403 High st., Perth Amboy
 Nieman, Solomon Z., 92 Bayard st., New Brunswick
 Panigrosso, Louis R., 284 Washington st., P. Amboy
 Pellicane, Anthony J., 183 Livingston av., NewBr.
 Platt, Thomas H., 307 N. Washington av., Dunellen
 Rineberg, Irving E., 94 Bayard st., New Brunswick
 Rona, Maurice, 159 Bayard st., New Brunswick
 Rothfuss, C. Howard, 490 Rahway av., Woodbridge
 Rothschild, Karl, 149 Livingston av., New Brunswick
 Rowland, Jonh H., 159 New st., New Brunswick
 Runyon, Laurance P., 80 Somerset st., New Bruns.
 Sandella, Joseph F., 169 New st., New Brunswick
 Saulsberry, Chas. E., 75 Livingston av., New Bruns.
 Scott, Frederick W., 103 Bayard st., New Brunswick
 Sender, Fannie, 193 Main st., South River

Sherman, W. E., 88 Schureman st., New Brunswick
Shull, John V., 84 Market st., Perth Amboy
Siegel, Isadore, 121 Market st., Perth Amboy
Silk, Chas. I., 278 High st., Perth Amboy
Sirott, Barnett H., 413 State st., Perth Amboy
Slobodien, Benjamin F., 107 Market st., P. Amboy
Smith, Arthur L. M., 62 Bayard st., New Brunswick
Smith, John V., 463 State st., Perth Amboy
Smith, Percy L., Georges rd., Dayton
Spencer, Ira T., 152 Main st., Woodbridge
Spritzer, Theo. D., S. Washington av., Dunellen
Steffens, Charles T., 307 N. Washington av., Dunel'n
Stein, William, 73 Livingston av., New Brunswick
Sullivan, Chas. J., 57 Paterson st., New Brunswick
Szuch, Nicholas, 159 Main st., South River
Taber, Frederick S., 49 Paterson st., New Brunsw'k
Toy, Calvert R., 22 Kirkpatrick st., New Brunswick
Tyrrell, George W., 380 State st., Perth Amboy
Uhr, Jacques S., 131 Livingston av., New Brunsw'k
Urbanski, Adrian X., 148 Market st., Perth Amboy
Urbanski, Matthew F., 314 Washington st., P. Amboy
Walker, Robert B., 108 Church st., New Brunswick
Walters, George M., 179 Main st., Woodbridge
Weber, John F., 264 Main st., South Amboy
Wetterberg, Louis F., 389 School st., Woodbridge
White, Harry J., Roosevelt Hospital, Metuchen
Wilentz, Wm. C., 188 Market st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

Associate Members

Bowman, Ned O., 1001 Georges rd., New Brunswick
Dunham, Malcolm M., 88 Grove av., Woodbridge
Fazio, Vincent J., 336 Main st., South Amboy
Fine, Irvin J., 30 Gordon st., Perth Amboy
Forney, Norman N., Jr., 94 N. Main st., Milltown

Gadek, Wm. V., 495 State st., Perth Amboy
Gerebin, Arpad, 511 Rahway av., Woodbridge
Goldman, Solomon, 43 Paterson st., New Brunswick
Greenwood, William R., Rutgers Univ., New Bruns.
Hesseltine, Clair E., 269 Brodowntown av., S. Amboy
Hoffman, Chas. W., 261 Henry st., South Amboy
Kelly, Leo J., 438 Amboy av., Perth Amboy
Kohut, George J., 473 Amboy av., Perth Amboy
Krafchik, Louis L., 100 Bayard st., New Brunswick
Lang, Joseph, 111B Market st., Perth Amboy
Levinson, Reuben, 241 State st., Perth Amboy
Normand, Alphonse F., 113 Market st., Perth Amb'y
O'Connell, James J., 59 Easton av., New Brunswick
Reitman, Norman, 161 New st., New Brunswick
Smith, John A., 106 Main st., South River
Smith, Joseph A., 133 Kearny av., Perth Amboy
Tucker, Sidney, 182 Market st., Perth Amboy
Ulan, Jerome, Main st., South River
Weiner, Henry T., 109 Market st., Perth Amboy
Wiesenfeld, Benjamin, 187 Main st., Woodbridge

Honorary Members

Applegate, Grover T., 71 Livingston av., New Bruns.
Van Dyke, Benjamin S., Cranbury

Resigned

Watson, Price T., 137 Main st., Milltown

Transferred

Isaac, B. C., to Essex County Medical Society
Pinnerman, R. B., to Mercer County Medical Society

Number of Active Members and basis of representation, 123, March 15, 1939.

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on fourth Wednesday of each month from October to June, inclusive. Annual Meeting in April

Active Members

Albright, Louis F., 118 Madison av., Spring Lake
Altschul, Frank J., 177 Garfield av., Long Branch
Baeseman, R. Winfield, 501 Grand av., Asbury Park
Bailey, Chas. P., 422 1st st., Lakewood
Baker, Elsworth F., State Hospital, Marlboro
Becker, Sidney D., 140 Maple pl., Keyport
Beveridge, Wm. W., 1000 Grand av., Asbury Park
Binder, Joseph, 101 3rd av., Long Branch
Blaisdell, C. Byron, 489 Broadway, Long Branch
Bornstein, Paul K., 415 S. Lake drive, Belmar
Boyd, John B., 141 Broad st., Red Bank
Brindle, Harry R., 501 Grand av., Asbury Park
Brown, Harvey S., 5 Club pl., Freehold
Brown, Kenneth G., 501 Grand av., Asbury Park
Bullwinkel, Fred'k, Ocean Blvd. & 4th av., Atl. H'l'ds
Campbell, Wm. K., 96 3rd av., Long Branch
Carey, David S., 11 E. Main st., Freehold
Carter, Joseph F. S., 142 Atkins av., Asbury Park
Ciampa, Ralph P. E., 383 Bath av., Long Branch
Clark, John C., 404 Asbury av., Asbury Park
Clayton, John C., 73 W. Main st., Freehold
Colby, Maxwell X., 287 Westwood av., Long Branch
dePons, Isabel S. C., 501 Grand av., Asbury Park
Dewis, Edwin G., 21 Westra st., Interlaken
Diamond, David I., Oceanport av., Oceanport
Edelson, Samuel, 1141 Corlies av., Neptune
Ellenson, Solomon S., 507 4th av., Asbury Park
Fairbanks, Warren H., 27 Broadway, Freehold
Featherston, Daniel F., 506 4th av., Asbury Park

Feinberg, Harry D., 384 2nd av., Long Branch
Feman, J. George, 141 Main st., Keansburg
Fenton, Tennant E., 320 Ludlow av., Spring Lake
Fisher, James A., 501 Grand av., Asbury Park
Freedman, Harold H., 63 W. Main st., Freehold
Gesswein, Carl A., 35 Church st., Matawan
Glazer, Edward, 501 Grand av., Asbury Park
Goff, Frank J., 64 Maple av., Red Bank
Gordon, J. Berkeley, N. J. State Hospital, Marlboro
Graves, Charles C., Jr., State Hospital, Marlboro
Guillium, Wm. H., 505 4th av., Asbury Park
Haines, Emerson S., 500 8th av., Asbury Park
Hancock, Michael Q., 705 D st., Belmar
Hardy, John W., 53 Main st., Farmingdale
Hausman, Samuel W., 50 W. Front st., Red Bank
Heatley, William, 23 Monmouth st., Red Bank
Herrman, Wm. G., 501 Grand av., Asbury Park
Hill, John A., 511 Cedar av., Allenhurst
Hodas, Sidney M., N. J. State Hosp., Marlboro
Holman, Francis W., 123 Broad st., Keyport
Holters, Otto R., 1002 Emory st., Asbury Park
Ingling, Harry W., 51 W. Main st., Freehold
Jamison, Wm. F., 501 Grand av., Asbury Park
Jones, Granville L., N. J. State Hospital, Marlboro
Jordan, Alexander D., 238 E. Main st., Manasquan
Jordan, Joseph C., 238 E. Main st., Manasquan
Kanses, Edmund S., 51 W. River rd., Rumson
Kazmann, Harold A., 406 Broadway, Long Branch
Krohn, Marc, Campbell av., Belford
Leighton, Robt. L., 401 Ludlow av., Spring Lake

Leonard, Lothair L., 615 Asbury av., Asbury Park
 Lewis, Jacob, 43 Court st., Freehold
 Lorenzo, Michael J., 75 Riverside av., Red Bank
 Lovett, Irving K., 110 E. Front st., Red Bank
 MacKenzie, Robt. A., 501 Grand av., Asbury Park
 Maher, John E., 90 3rd av., Long Branch
 Makin, John B., 501 Grand av., Asbury Park
 Manahan, Daniel V., 55 E. Front st., Red Bank
 Martin, Leonard J., 6 Borden av., Asbury Park
 Mason, Howard B., 90 W. Main st., Freehold
 Matthews, Wm., 139 Broad st., Red Bank
 McDonnell, George J., 80 W. Main st., Freehold
 McKelvie, Julius C., 55 Rockwell av., Long Branch
 McTague, Robert S., 9 Memorial Pkwy., Atl.Highl'ds
 Metzger, Karl F., 603 9th av., Belmar
 Miele, Frank A., 314 Carr av., Keansburg
 Miller, Samuel T., 527 Bangs av., Asbury Park
 Moffat, Barclay W., Nut Swamp rd., Red Bank
 Murphy, Chas. M., 21 Main st., Farmingdale
 Neiderhoffer, Sydney L., 469 Broadway, Long Br'ch
 Nichols, Stanley H., 501 Grand av., Asbury Park
 Niemtzow, Frank, 55 E. Main st., Freehold
 O'Mara, John A., 314 St. Clair av., Spring Lake
 Opfermann, John L., 167 Bay av., Highlands
 Osborn, Adam D., 519 6th av., Belmar
 Parker, James W., 175 Shrewsbury av., Red Bank
 Parry, Oliver K., 601 Bangs av., Asbury Park
 Perrine, Cornelius C., 668 River rd., Fair Haven
 Perrotta, Anthony J., 94 Maple av., Red Bank
 Pieper, Howard C., 426 Bath av., Long Branch
 Pietri, Raoul, 501 Grand av., Asbury Park
 Podell, A. Alfred, 51 E. Front st., Red Bank
 Pons, Carlos A., 501 Grand av., Asbury Park
 Pregnall, James P., 501 Grand av., Asbury Park
 Quirk, Martin A., 90 W. Front st., Red Bank
 Reynolds, Donald G., 64 W. Main st., Freehold
 Reynolds, George G., 64 W. Main st., Freehold

Robinson, Ernest A., 149 Atkins av., Asbury Park
 Robinson, Wm. A., 62 Main av., Ocean Grove
 Rowland, James J., 321 Bay av., Highlands
 Rubin, Adrian D., 401 1st av., Asbury Park
 Rullman, Walter A., 58 W. Front st., Red Bank
 Sacco, Gregory E., 191 Broad st., Red Bank
 Sayre, William D., 69 Maple av., Red Bank
 Schlossbach, Theodore, 94 S. Main st., Ocean Grove
 Schmidt, Albert F., 81 Union av., Manasquan
 Scott, Elmer A., Belle Mead San., Belle Mead
 Sewell, Stephen, 320 Passaic av., Spring Lake
 Shanik, William, 600 4th av., Asbury Park
 Silverstein, Max, 605 1st av., Asbury Park
 Slocum, Harry B., 263 Bath av., Long Branch
 Stevenson, Geo. S., R. D. No. 1, Everett rd., R'dBank
 Strahan, Frank G., 473 Broadway, Long Branch
 Straughn, Clinton C., 23 Monmouth st., Red Bank
 Strauss, Arthur, 130 Pavilion av., Long Branch
 Trippe, Clarence M., 702 Asbury av., Asbury Park
 Upham, Helen F., 305 3rd av., Asbury Park
 Villapiano, Jos. G., 701 Sunset av., Asbury Park
 Wallin, Alfred C., 166 Main st., Matawan
 Watkins, Robert E., 517 5th av., Belmar
 Wiener, Joseph, 601 Bangs av., Asbury Park
 Wilbur, Franklin L., 711 Grand av., Asbury Park
 Wilkins, Stanley O., 47 E. Front st., Red Bank
 Wilson, Robert B., 91 Broad st., Red Bank
 Wise, Lester D., 119 Morris av., Long Branch
 Woodruff, Ralph G., Main st., Englishtown
 Woronoff, Murray, 120 Main st., Keyport

Transferred

Sands, O. L., Asbury Park, to New York
 Strauss, Bernard, Freehold, to Brooklyn, N. Y.

Number of Active Members and basis of representation, 126, March 15, 1939.

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in each month from October to June, inclusive. Annual Meeting in June.

Active Members

Abell, Elvira D., R. D. No. 2, Morristown
 Ackermann, Edward, 5 Richards av., Dover
 Allaben, Anna L., 165 South st., Morristown
 Atkinson, John M., 93 Greenwood av., Madison
 Baker, Augustus L. L., 389 W. Blackwell st., Dover
 Beaver, Jennie D., 44 Elm st., Morristown
 Bertha, Nicholas A., 275 S. Main st., Wharton
 Bird, Frank L., Main st., Netcong
 Blanchard, Charles L., 28 E. Blackwell st., Dover
 Bobadilla-Riquelme, Juan E., 27 E. Bl'kw'll st., Dov'r
 Booth, Wm. K., 304 William st., Boonton
 Bowers, F. Clyde, Mountain av., Mendham
 Byrne, James A., 181 South st., Morristown
 Carberry, Edw. T., 67 S. Main st., Wharton
 Cohen, Oscar H., 115 Church st., Boonton
 Collins, Laurence M., Greystone Park
 Comeau, George W., 415 Speedwell av., Morris Pl'ns
 Costello, William F., 55 W. Blackwell st., Dover
 Coultas, Aldo B., 1 Madison av., Madison
 Crandell, C. Archie, N. J. State Hosp., Greystone P'k
 Curry, Marcus A., N. J. State Hosp., Greystone Park
 Deichman, Chas. H., 39 Elm st., Morristown
 Donovan, Joseph, N. J. State Hosp., Greystone P'k
 Earp, Ruth, 15 Olcott av., Bernardsville
 Eckhardt, Ralph A., 50 Green Village rd., Madison
 Evans, Edgar J., Hinchman av., Denville
 Failmezger, Theodore R., 60 Green av., Madison
 Falvello, Nicholas A., 28 Wetmore av., Morristown

Ferriss, Ruth B., 51 Maple av., Morristown
 Forbes, John S., Jr., Cedar st., Basking Ridge
 French, Frank S., 284 Morris av., Mountain Lakes
 Frost, Inglis F., 181 South st., Morristown
 Geary, Daniel J., 40 Maple av., Morristown
 Gibb, William B., 26 Maple av., Morristown
 Gilbertson, Robert L., 500 W. 57th st., N. Y. C.
 Glazebrook, Francis H., 37 Ogden pl., Morristown
 Gordon, Charles D., Mt. Arlington
 Graddick, Lester W., 22 Sussex av., Morristown
 Gregory, Marie F., 50 Green Village rd., Madison
 Griscom, I. Norwood, 204 Church st., Boonton
 Hampton, Geo. R., Greystone Park
 Harrington, J. Henry, 126 E. Ma'n st., Rockaway
 Hatch, Harold S., Shonghum Mt. Sana., Morristown
 Haven, Samuel C., 14 Elm st., Morristown
 Heinig, Frank G., 124 Cornelia st., Boonton
 Hiler, Stuart A., 62 Rockaway av., Rockaway
 Hogan, Marshall D., 311 W. Main st., Boonton
 Hubert, Antonio O., 131 E. Main st., Rockaway
 Johnson, George L., 27 High st., Morristown
 Judd, Wilbur M., N. J. State Hosp., Greystone P'k
 Kessler, Edward I., N. J. State Hosp., Greystone P'k
 King, Alden P., 44 W. Blackwell st., Dover
 Kinkead, Hilda, 51 Highland av., Madison
 Kossmann, Walter J., Long Valley
 Krauss, Fletcher I., 201 Main st., Chatham
 Kuite, George B., 435 Speedwell av., Morris Plains
 Lane, Arthur G., Greystone Park

Larson, Henry M., 35 Franklin st., Morristown
Lathrope, Geo. H., 965 Broad st., Newark
Mathews, Raymond H., 186 South st., Morristown
McCluskey, Harry B., Parsippany rd., Whippany
McElroy, Ervin, 20 Main st., Rockaway
McMahon, Bernard C., 18 DeHart st., Morristown
McMurray, George B., N. J. State Hosp., Gr'stoneP'k
Michell, George E., 221 High st., Hackettstown
Mills, Clifford, 36 Maple av., Morristown
Musetto, Carmelo A., 135 Cornelia st., Boonton
Mutchler, Julia C., 36 W. Blackwell st., Dover
Navazio, Attilio, 185 Speedwell av., Morristown
Nicoll, George L., 48 W. Blackwell st., Dover
Pinckney, Frank H., 186 South st., Morristown
Plume, Clarence A., Main st., Succasunna
Polakoff, Joseph, Main st., Stirling
Pottinger, William E., 6 Altamont court, Morristown
Prager, Bert A., 251 Main st., Chatham
Rice, Franklin W., 184 South st., Morristown
Rosenberg, Alvin A., 22 High st., Morristown
Rubens, Otto, 27 E. Blackwell st., Dover
Rubin, Henry S., 11 High st., Morristown
Ryman, Merlin T., 5 Dunbar st., Chatham
Schulman, Robert, Aurora Health Institute, M'rrist'n
Scott, Harold R., 10 Speedwell av., Morristown
Seward, Frederick H., 40 Green Village rd., Madison
Sherman, Benjamin, Aurora H'lth Institute, M'rrist'n
Sherman, Byron G., 52 Maple av., Morristown
Smith, Malcolm K., 22 Madison av., Morristown
Spencer, Alvan, 395 W. Blackwell st., Dover
Stage, Earl DeW., 11 James st., Morristown
Talmage, Wm. G., Main st. & Hillside av., Succasunna
Tanner, Walter L., 12 DeHart st., Morristown

Taylor, Malcolm C., N. J. State Hosp., GreystoneP'k
Teller, D. Woolsey, Jr., 26 Maple av., Morristown
Terrerri, D. Joseph, 30 High st., Morristown
Teskey, Stanley, 10 Anderson rd., Bernardsville
Thomas, Thomas S., Jr., 18 Elm st., Morristown
Truax, Alfred J., 121 Church st., Boonton
Van Sickle, Albert W., Chester
von Deilen, Henry O., 26 Maple av., Morristown
Voorhies, William S., Jr., Greystone Park
Voss, J. Landon, 21 Mt. Airy rd., Bernardsville
Wade, Francis A., 196 South st., Morristown
Ward, Albert J., 39 Elm st., Morristown
Washburn, Philip C., N. J. State Hosp., Gr'stoneP'k
Williams, Louis E., 80 Green av., Madison
Woodman, Charles B., 181 South st., Morristown
Young, George J., 60 Maple av., Morristown
Zimmerman, Robert F., 28 Washington av., Morrist'n

Courtesy Member

Joy, Homer T., 54 Madison av., Morristown

Honorary Members

Knight, A. S., Far Hills
vanBeuren, Frederick T., Jr., Morristown

Transferred

Douglass, William C., to Somerset Co. Med. Society
French, Frank S., from New York Co. Med. Society
Rossi, Bartolomeo C., to Essex Co. Medical Society
Tanner, Walter L., from Mass. State Medical Society

Number of Active Members and basis of representation, 107, March 15, 1939.

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month except June, July, August and September. Annual Meeting in May.

Active Members

Bierach, Jules L., 106 Washington st., Toms River
Blumberg, A. Wm., New Egypt
Buermann, Robert, 206 Madison av., Lakewood
Bunnell, Frederick N., 22 S. Main st., Barnegat
Carmona, Luis R., 141 Wood st., Tuckerton
Dodd, Wm. E., Beach Haven
Falkinburg, LeRoy W., Forked River
Goldstein, Abraham, 404 Madison av., Lakewood
Green, Thomas J., New Egypt
Halbach, Robert McC., 802 N. Main st., Toms River
Henriksen, Jay B., 422 River av., Point Pleasant
Herbener, Eugene G., 423 3rd st., Lakewood
Hogan, Jas. J., New Egypt
Ivory, Harry S., cor. Richm'n & Form'n av., Pt. Pl'snt
Lehmacher, Frank, 16 Central av., Lakewood
McIlvaine, Wm. E., 104 3rd st., Lakewood
Menge, Carl, 236 Washington st., Toms River

Obert, Josiah E., New Egypt
Sawyer, Blackwell, 109 Washington st., Toms River
Schneider, Clinton R., 125 N. Green st., Tuckerton
Sickel, Emanuel M., 220 Madison av., Lakewood
Szold, Norman F., 701 Princeton av., Lakewood
Taylor, Raymond, 58 Madison av., Lakewood
Thompson, Theodore F., 316 1st st., Lakewood
Tilles, Samuel, 44 Sheridan av., Seaside Heights
Towbin, Adolph, 326 3rd st., Lakewood
Witte, C. N., 422 River av., Point Pleasant

Honorary Members

Collins, R. H., Commander U. S. N., Lakehurst
Green, Carl, Lt., U. S. N., Lakehurst

Number of Active Members and basis of representation, 27, March 15, 1939.

PASSAIC COUNTY (16)

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on second Thursday of each month except June, July, and August. Annual Meeting in May.

Active Members

- Allen, Arthur A., 365 Park av., Paterson
 Allen, James M., 657 Main av., Passaic
 Apter, Abraham H., 528 E. 29th st., Paterson
 Armstrong, Robt. R., 114 Pennington av., Passaic
 Ash, Frank W., 180 Carroll st., Paterson
 Atkinson, Jas. W., 603 S. Maple av., Glen Rock
 Atwood, Ed. A., 360 Park av., Paterson
 Averbach, Jacob, 435 Clifton av., Clifton
 Barlow, Frank A., 965 Madison av., Paterson
 Barolsky, Benj., 306 Broadway, Paterson
 Barr, Joseph, 975 Madison av., Paterson
 Becker, Geo. L., 646 E. 28th st., Paterson
 Becker, Leo V., 69 Ward st., Paterson
 Bender, Theo., 666 Broadway, Paterson
 Benjamin, Joseph F., 203 Godwin av., Ridgewood
 Bergin, Jos. V., 315 Broadway, Paterson
 Berk, M. David, 33 Bartholf av., Pompton Lakes
 Berkhout, Peter G., 106 Haledon av., Prospect Park
 Beshlian, Hagop K., 7 Lee pl., Paterson
 Biczak, Arkad K., 311 Lexington av., Clifton
 Birely, Morris F., 170 E. Ridgewood av., Ridgewood
 Bohl, Louis J., 320 Broadway, Paterson
 Bongiorno, Henry D., 516 River st., Paterson
 Bonyne, Henry A., 123 Prospect st., Ridgewood
 Bornstein, David, 80 Carroll st., Paterson
 Botbyl, Burt W., 927 Madison av., Paterson
 Boylan, Lawrence B., 630 Main st., Paterson
 Brancato, Peter, 17 Church st., Paterson
 Brevoort, Henry H., 54 Main st., Lodi
 Brogan, Francis B., 84 Ward st., Paterson
 Bromberg, Chas. B., 107 Lexington av., Passaic
 Brooks, Sidney, 62 12th av., Paterson
 Budd, J. Reuben, 379 Clifton av., Clifton
 Bullen, Victor E., 148 Hamilton av., Paterson
 Butterfield, Arey A., 135 Aycrigg av., Passaic
 Calligaro, Egildo A., 75 Clifton av., Clifton
 Carlisle, John H., 129 Prospect st., Passaic
 Carlough, David J., 426 Ellison st., Paterson
 Catanzaro, Francesco, 151 Jefferson st., Passaic
 Chapnick, Maurice M., 117 Paterson st., Paterson
 Chase, William E., 137 Gregory av., Passaic
 Cherry, Homer H., Valley View Sana., Paterson
 Chester, Saul W., 634 Broadway, Paterson
 Chilton, Forrest S., Pompton Plains
 Chipley, Bascomb L., Valley View Sana., Paterson
 Chrisman, Irving, 408 Ellison st., Paterson
 Ciccone, Anthony C., 389 Grand st., Paterson
 Clay, Thomas A., 351 Totowa av., Paterson
 Close, Byron H., Bloomingdale
 Cogan, Henry, 128 Carroll st., Paterson
 Cohen, Julian, 475 Park av., Paterson
 Cohen, Louis, 257 Paulison av., Passaic
 Cohen, M. Marvin, 137 Graham av., Paterson
 Cohn, Isidor, 231 Lexington av., Passaic
 Cole, L. Frank, 242 Broadway, Passaic
 Connolly, T. Vincent, 56 Hamilton st., Paterson
 Coppola, Edward A., 22 Garretsee pl., Clifton
 Cortese, Alvin E., 26 Ward st., Paterson
 Cotton, Norman T., 219 Graham av., Paterson
 Cremens, John F., 144 Carroll st., Paterson
 Crescente, Fred J., 827 Madison av., Paterson
 Crounse, David R., 84 Broadway, Passaic
 Curtis, Austin M., Jr., 445 Van Houten st., Paterson
 Davis, A. Hobson, Paterson Gen. Hosp., Paterson
 Dawson, Harry, 618 E. 24th st., Paterson
 DeBell, Peter J., 239 Burgess pl., Passaic
 DeGrace, Francis H., 344 Gregory av., Passaic
 Deich, Samuel R., 162 Lexington av., Passaic
 Delario, Anthony J., 294 Broadway, Paterson
 Del Mauro, Alphonse, 417 21st av., Paterson
 De Mattia, Michael, 71 Ward st., Paterson
 De Rosa, Armand, 290 Union Blvd., Totowa Bor'gh
 De Rosa, John, 150 Fair st., Paterson
 Desmet, Victor F., 324 Broadway, Paterson
 De Yoe, Leon E., 602 Broadway, Paterson
 Dingman, Norman McL., 330 Broadway, Paterson
 Donnelly, Joseph E., 451 Market st., Paterson
 Douglass, Stephen A., Valley View Sana., Paterson
 Dow, Robt. F., 272 Park av., Paterson
 Drake, Daniel E., Union Valley rd., Newfoundland
 Duncan, Owsley B., 606 E. 26th st., Paterson
 Dunning, Walter L., 533 River st., Paterson
 Dwyer, Henry E., 261 Madison av., Passaic
 Dwyer, Wm. A., 99 Park av., Paterson
 Edlkraut, Edward C., 129 Highland av., Passaic
 Ehrenfeld, Edward, 185 Lexington av., Passaic
 Ehrenfeld, Irving, 185 Lexington av., Passaic
 Eklings, Frank P., 221 Broadway, Paterson
 Feigenoff, Israel, 665 Broadway, Paterson
 Fenster, Morton N., 261 Main st., Passaic
 Ferrary, Paul B., 232 Totowa rd., Totowa Boro
 Fiering, Abraham M., Pompton Tnpk., M'tain V'w
 Fishbein, Elliot, Valley View Sana., Paterson
 Fisher, Samuel, 808 Madison av., Paterson
 Fliteroft, William, 510 River st., Paterson
 Freedman, Jacob S., 178 Hamilton av., Passaic
 Gallardo, Agustín, 61 Lakeside av., Pompton Lakes
 Gallo, James S., 32 Zabriskie st., Haledon
 Geiger, Harold C., West Milford
 Giambra, Sante M., 666 Broadway, Paterson
 Gillson, Hugh V., 21 Lee pl., Paterson
 Gillson, John T., 170 Broadway, Paterson
 Ginsburg, Samuel, 227 Paulison av., Passaic
 Glasgow, Thomas M., 120 Passaic av., Passaic
 Gochman, Harry M., 166 Hamilton av., Paterson
 Goldenberg, Raphael R., 588 E. 27th st., Paterson
 Golding, Harry N., 180 Carroll st., Paterson
 Gordon, Abel, 616 Main av., Passaic
 Gordon, Osher, 119 Lexington av., Passaic
 Gordon, Samuel, 515 Broadway, Paterson
 Gormley, Cyrus M., 6 Roberts st., Butler
 Gould, J. Howard, 263 Franklin av., Ridgewood
 Graham, Archibald F., 42 Park av., Paterson
 Graham, Theodore K., 279 Park av., Paterson
 Greengrass, Jacob J., 146 Broadway, Paterson
 Guarraia, Joseph, 285 Van Winkle av., Hawthorne
 Hagen, Orville R., 266 Van Houten st., Paterson
 Hall, Wayne W., 266 Van Houten st., Paterson
 Hambricht, Arthur M., Wyckoff av., Ramsey
 Harreys, Chas. W., 714 Broadway, Paterson
 Hatem, Elias J., 1046 Main st., Paterson
 Hillmann, Frederick C., 64 Hamilton st., Paterson
 Hirsch, Samuel, 118 Lexington av., Passaic
 Hollingsworth, Herman H., 86 First st., Clifton
 Holmes, Thomas J. E., 151 Fair st., Paterson
 Holster, Stephen G., 951 Madison av., Paterson
 Holt, Herman H., 256 Graham av., Paterson
 Hughes, John V., 150 Prospect st., Passaic
 Ianacone, John A., 310 Fifth av., Paterson
 Irraggi, Jas. V., 79 Broadway, Passaic
 Irving, Albert S., 318 Howard av., Fair Lawn
 Ives, Edwin I., 24 Stevens av., Little Falls
 Izenberg, David, 104 Carroll st., Paterson
 Jahn, Albert G., 657 Main av., Passaic
 Jani, Frank F., 297 Lexington av., Passaic
 Jarmulowsky, Harry, 181 E. 33rd st., Paterson
 Jehl, Joseph R., 305 Clifton av., Clifton

Joelson, Morris S., 577 Broadway, Paterson
Joffe, Philip M., 556 E. 28th st., Paterson
Joffe, Sidney H., 556 E. 28th st., Paterson
Johnsen, Sigurd W., 49 Passaic av., Passaic
Joseph, Morris, 271 Lexington av. Passaic
Joyce, Leo H., 259 Madison st., Passaic
Kane, Charles J., 984 E. 23rd st., Paterson
Keating, Charles A., 177 Ellison st., Paterson
Keller, Franklin J., 297 Diamond Br. av., Hawthorne
Keller, Michael L., 268 Park av., Paterson
Kennedy, A. Andrew, 6 Eagle av., Paterson
Kennedy, Eugene T., 413 Wanaque av., Pompton Lakes.
Keppler, Chas., Jr., 723 Allwood rd., Clifton
Kim, Gay B., St. Joseph's Hospital, Paterson
Kinney, Burton O., 41 Lincoln av., Little Falls
Kleiner, Samuel, 162 Hamilton av., Paterson
Koenig, Bertram, 306 Broadway, Paterson
Koerber, George, 136 Prospect st., Passaic
Kovaleski, Walter A., 154 Passaic st., Passaic
Kovin, Abraham, 123 Lexington av., Passaic
Kowalski, Louis J., 66 Fourth st., Passaic
Kroll, Adolph, 103 Van Buren st., Passaic
Kuhl, John P., 38 Main st., Butler
Laauwe, Harold W., 198 Haledon av., Paterson
Labash, Charles S., 83 Quincy st., Passaic
Landaw, Louis, 631 E. 26th st., Paterson
Lawrence, Elias D., 365 Union av., Paterson
Leach, John E., 372 Park av., Paterson
Lee, Frederick P., 606 E. 27th st., Paterson
Leibovitz, Altan C., 261 Lexington av., Passaic
Lemay, Albert T., 532 14th av., Paterson
Leonard, Edward F., 771 Madison av., Paterson
Levendusky, Daniel E., 52 Market st., Passaic
Levine, David B., 647 Broadway, Paterson
LeVine, Israel, 215 Broadway, Paterson
Levine, Sidney C., 459 Park av., Paterson
Levinsohn, Sandor A., 584 Broadway, Paterson
Levy, Herman, 219 Lexington av., Passaic
Linares, Angelo C., 208 Market st., Paterson
Lipton, Louis, 67 Passaic av., Passaic
Lobsenz, Nathan P., 294 Broadway, Paterson
Lomauro, James R., 145 Lexington av., Passaic
London, Jules R., 153 Jefferson st., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucent, S. Bell, 2 First st., Little Falls
Luksteid, Casimir J., 326 Park av., Paterson
MacAlister, Wm. W., 171 Carroll st., Paterson
MacGregor, Allan W., 379 Ellison st., Paterson
MacGuffie, Robert N., 657 Main av., Passaic
MacLay, Joseph A., 239 Broadway, Paterson
MacMillan, C. Wright, 23 Passaic av., Passaic
Maffongelli, Jos. A., 494 River st., Paterson
Magennis, Bryan C., 272 Broadway, Paterson
Magnes, Max, 271 Park av., Paterson
Manly, Thos. E., 390 Park av., Paterson
Manzione, Frank A., Passaic Co. Welf. Home, Pr'kness
Maps, Howard L., 53 Passaic av., Passaic
Marini, Dominick, 40 Henry st., Passaic
Markel, Albert G., 450 Park av., Paterson
Markowitz, Louis, 16 Church st., Paterson
Marrocco, Wm. A., 47 Ward st., Paterson
Marsh, Elias J., 400 Van Houten st., Paterson
Martin, Theodore, 98 Haledon av., Paterson
Masucci, Alberico, 34 Ward st., Paterson
Matthews, Leonard M., 655 Main av., Passaic
McBride, Andrew F., 30 Church st., Paterson
McCamey, Kenneth E., 612 E. 29th st., Paterson
McCarthy, George L., 506 Union av., Paterson
McCoy, John C., 292 Broadway, Paterson
McCue, John B., 912 Lincoln av., Pompton Lakes
McDede, Frank F., 922 Main st., Paterson
McDonald, Richard J., 80 Park av., Paterson
McPherson, M. E., 141 Diamond Br. av., Hawthorne
Meier, Wm. U., 1062 Ringwood av., Haskell

Meloney, Lester F., 156 Second st., Clifton
Mendelsohn, David H., 576 Broadway, Paterson
Meneve, Alfred D., 373 Broadway, Paterson
Meyers, Francis R., 627 E. 24th st., Paterson
Michela, Luigi S., 206 Carroll st., Paterson
Mills, Alvah V., Lindsley rd., Little Falls
Missonellie, Wm., 404 Lafayette av., Hawthorne
Mitchell, Chas. R., 311 Broadway, Paterson
Morici, Theodore, 80 Howe av., Passaic
Morrill, James P., 310 Broadway, Paterson
Moscoe, Harry A., Main st., Lincoln Park
Mott, Joseph E., 426 Park av., Paterson
Murn, Charles J., 48 Smith st., Paterson
Neer, William, 245 Broadway, Paterson
Nemirow, Martin, 234 Lexington av., Passaic
Nesbitt, Elizabeth, No. Jersey Tr'n'g Sch'l, Little Falls
Norval, William A., 419 Main st., Paterson
Notkin, Meyer, 559 Broadway, Paterson
Noto, Philip, 158 Washington pl., Passaic
Nye, Howard H., 174 Carroll st., Paterson
O'Brien, Dennis M., 154 Lexington av., Passaic
O'Brien, Jeremiah H., 204 Madison st., Passaic
Okin, Irving, 165 Passaic av., Passaic
Oram, Joseph H., 495 Broadway, Paterson
Pal, Darbari R., 32 Clark st., Paterson
Palma, Nicholas, 116 17th av., Paterson
Palmer, Francis R., 249 Lexington av., Passaic
Paris, William, 518 E. 25th st., Paterson
Park, M. Benjamin, 360 Park av., Paterson
Patella, Fulvio, 232 Broadway, Paterson
Pearlman, Saul J., 210 Lexington av., Passaic
Pelusio, August N., 269 Carroll st., Paterson
Pernetti, Anthony Miles, 320 Broadway, Paterson
Phelps, James E., 203 Park av., Paterson
Piasecki, Chester A., 741 E. 23rd st., Paterson
Piller, Jacob, 245 Broadway, Paterson
Pink, Solomon H., 21 High st., Butler
Plinke, Fritz W., 159 Lexington av., Passaic
Polizzotti, Joseph L., 193 Park av., Paterson
Polowe, David, 555 E. 27th st., Paterson
Prince, Robert A., 567 Broadway, Paterson
Provisor, Benjamin, 141 Lexington av., Passaic
Raab, Michael, 111 Lexington av., Passaic
Radest, Louis J., 158 Hamilton av., Paterson
Randazzo, Anton P., 82 Prospect st., Passaic
Rauschenbach, Paul E., 225 Broadway, Paterson
Rauschenbach, Paul E., Jr., 174 Carroll st., Paterson
Reeves, Ernest, 195 Lexington av., Passaic
Reynolds, Earle C., 655 Main av., Passaic
Reynolds, Harry C., 657 Main av., Passaic
Richards, Paul S., 1 Main st., Butler
Rinzler, Harry G., 127 Van Houten av., Passaic
Ritter, John J., 741 E. 22nd st., Paterson
Roemer, Jacob, 213 Broadway, Paterson
Rothman, Theodore, 494 Park av., Paterson
Roy, Jos. N., 95 17th av., Paterson
Ruocco, William B., 416 River st., Paterson
Russell, Chas. B., 119 Hamilton av., Paterson
Sabarese, Theodore C., 122 Marsellus pl., Garfield
Saffron, Morris H., 292 Paulison av., Passaic
Salzman, Nathan, 714 Broadway, Paterson
Sanfacon, Thomas A., 340 Park av., Paterson
Santangelo, Emil L., 349 Broadway, Paterson
Scheffrin, Alex E., 235 Lexington av., Passaic
Schubert, Roy R., 408 Union av., Paterson
Schultz, A. M., 379 Union av., Paterson
Schwartz, William, 155 Lexington av., Passaic
Schwartzberg, Frederick I., 522 Broadway, Paterson
Scielzo, Nicholas Fred, 369 Park av., Paterson
Scribner, Charles H., Hamburg Tnpk., Preakness
Shapiro, David, 707 Broadway, Paterson
Shapiro, Lou's G., 375 Broadway, Paterson
Shipman, Meyer P., 237 Broadway, Paterson
Shippee, David N., 648 Ringwood av., Wanaque

Shippee, J. N., 648 Ringwood av., Wanaque
 Shulman, Abraham, 528 E. 29th st., Paterson
 Silverman, Irving A., 260 Dayton av., Clifton
 Simkin, Abraham, 247 Broadway, Passaic
 Simon, Julius J., 174 Columbia av., Passaic
 Simon, Morris L., 174 Washington pl., Passaic
 Simon, Philip H., 174 Columbia av., Passaic
 Siveke, John, 106 Lexington av., Passaic
 Slaff, Florence, 16 Grove st., Passaic
 Sloan, Samuel L., 182 Belmont av., Paterson
 Smith, Carroll D., 320 Broadway, Paterson
 Smith, Elroy W., 655 Main av., Passaic
 Smith, Leon A., 655 Main av., Passaic
 Sobel, I. Jerome, 136 Broadway, Passaic
 Spickers, William, 6 Church st., Paterson
 Stark, Jacob, 645 Broadway, Paterson
 Stein, Harry M., 227 W. Broadway, Paterson
 Steinberg, Benjamin L., Singac
 Stinson, Richard, 641 E. 18th st., Paterson
 Stokes, James S., 85 Park av., Paterson
 Stoltz, Raymond R., 23 Passaic av., Passaic
 Stouter, Francis L., 29 17th av., Paterson
 Sucoff, Moses C., 158 Hamilton av., Passaic
 Sullivan, William M., Jr., 43 Passaic av., Passaic
 Summerill, Frederick, 424 Terhune av., Passaic
 Surgent, Geo. W., 168 Clifton av., Clifton
 Sutherland, William W., 400 Broadway, Paterson
 Szymanski, John J., 616 Main av., Passaic
 Taber, Leslie R., 266 Van Houten st., Paterson
 Tellman, Daniel H., 120 Lexington av., Passaic
 Temple, Arthur H., 164 Jefferson st., Passaic
 Terhune, Percy H., 358 Owen st., Radburn
 Thomas, Irene O., 275 Lafayette av., Hawthorne
 Thorne, Wm. P., 254 Main st., Butler
 Thron, Leopold E., 586 E. 29th st., Paterson
 Todd, Francis H., 83 Auburn st., Paterson
 Tomkins, Wm., 105 Fairmount rd., Ridgewood
 Tuers, George E., 418 Park av., Paterson
 Tweddel, George K., 239 Broadway, Paterson
 Udinsky, Hyman J., 29 Passaic av., Passaic
 Vanderbeek, Andrew B., 174 Broadway, Paterson
 Vanderbeek, Frank B., 407 Park av., Paterson
 Vander Clock, Cornelius, 23 Passaic av., Passaic
 Van Eerde, Albert, 339 Lafayette av., Hawthorne
 Van Riper, Arthur W., 607 Main av., Passaic
 Van Schott, Gerard J., Jr., 245 Lexington av., Pas'c
 Van Urk, Frederick T., 663 Main av., Passaic
 Van Winkle, John S., 297 Broadway, Paterson
 Vosburgh, Fred, 61 Passaic av., Passaic
 Vreeland, Clarence LeF., 516 W'n'que av., Pmptn.Lks.
 Vreeland, Ralph J., 266 Van Houten st., Paterson
 Walker, Harold G., Everett av., Wyckoff
 Wallace, Marc J., 152 Lakeview av., Clifton
 Walton, Gordon G., 17 Church st., Paterson
 Warburton, Jack C., 333 Park av., Paterson
 Ward, Albert H., 404 Totowa av., Paterson
 Warren, David E., 154 Broadway, Passaic
 Warren, Earl L., 266 Van Houten st., Paterson
 Warren, Jacob, 308 18th av., Paterson
 Wassing, Hans, 695 Broadway, Paterson
 Weinert, Henry V., 128 Market st., Passaic
 Weintraub, Wm. L., 400 Broadway, Paterson
 Westerhoff, Peter, 51 Highland av., Midland Park

Wethers, Wm., 171 Market st., Passaic
 White, Richard E., 303 Crooks av., Paterson
 Wilkinson, Boyd E., 266 Van Houten st., Paterson
 Williams, Hiram, 230 Lexington av., Passaic
 Winters, Walter M., 288 Broadway, Paterson
 Wishnack, Meyer, 318 Broadway, Paterson
 Wolf, Israel J., 231 E. 31st st., Paterson
 Wolfson, Harry, 324 Broadway, Paterson
 Wry, Dean A., 234 Dayton av., Clifton
 Yachnin, Samuel C., 32 Ridge rd., Lyndhurst
 Yager, J. Allen, 420 Broadway, Paterson
 Yates, John S., 414 Ellison st., Paterson
 Yolken, Harry, 246 E. 31st st., Paterson
 Zalewski, Irene J., 125 Market st., Passaic

Associate Members

Alpren, Bernard F., 34 Auburn st., Paterson
 Balles, Edward S., 295 Broadway, Paterson
 Burrill, Benjamin B., Jr., Pompton av., Pompton Pl.
 Cuono, Joseph D., 276 E. 19th st., Paterson
 Della Penna, Sam'l J., 502 Ramapo av., PomptonLks.
 Esposito, Anthony L., 478 Clifton av., Clifton
 Fishbein, Isadore L., 277 Broadway, Paterson
 Fraulo, Louis, 310 Crooks av., Clifton
 Gelman, Sidney, 345 Broadway, Paterson
 Graeter, F. Albert, 265 Gregory av., Passaic
 McBride, Andrew F., Jr., 655 Broadway, Paterson
 Michelson, Henry, 557 Broadway, Paterson
 O'Brien, William A., 158 Broadway, Passaic
 Oppen, Phillip, 715 Broadway, Paterson
 Pasternack, Elroy, 255 Harrison st., Passaic
 Relly, Thomas F., 187 Second st., Clifton
 Schwartz, Jacob, 8-04 Fair Lawn av., Fair Lawn
 Vermeulen, Abram, 242 Haledon av., Paterson
 Weisman, Stephen L., 566 Broadway, Paterson

Courtesy Member

Reading, H. E., 538 E. 29th st., Paterson

Emeritus Members

Atkinson, James W., 603 S. Maple av., Glen Rock
 Chase, William E., 585 Main av., Passaic
 Flitcroft, William, 510 River st., Paterson
 Gillson, John T., 170 Broadway, Paterson
 Kane, Charles J., 984 E. 29th st., Paterson
 Magennis, Bryan C., 271 Broadway, Paterson
 McBride, Andrew F., 30 Church st., Paterson
 McCoy, John C., 292 Broadway, Paterson
 Neer, William, 245 Broadway, Paterson
 Scribner, Charles H., Hamburg Tnpk., Preakness
 Stinson, Richard, 641 E. 18th st., Paterson
 Terhune, Percy H., 171 Paulison av., Passaic

Resigned

Bradasch, George A.

Transferred

Ring, Herman B., to Los Angeles, Calif.

Number of Active Members and basis of representation, 363, March 15, 1939.

SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the second Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

Active Members

Bramble, Halsey S., Front & Chestnut sts., Elmer
Caggiano, John D., 165 W. Main st., Pennsgrove
Chesler, Maurice, 124 W. Broadway, Salem
Church, Franklin H., 86 W. Broadway, Salem
Cox, John R., 37 W. Main st., Pennsgrove
Davison, C. Spencer, 7 Chestnut st., Salem
Davison, Wilbur S., Pittsf'd st. & Salem rd., Pennsv'le
Dunn, John S., 75 Market st., Salem
Evans, Edgar E., 12 Ziegler Tract, Pennsgrove
Fleming, Chas. L., 42 W. Main st., Pennsgrove
Green, David W., 69 Market st., Salem
Hilliard, William T., 105 Market st., Salem
Hummel, Lee C., 109 W. Broadway, Salem
James, William H., Main st., Pennsville
Jirouch, Edwin A., 18 Ziegler Tract, Pennsgrove

Lipkin, Isadore, 108 W. Main st., Pennsgrove
Lummis, Clarence P., 40 Delaware av., Pennsgrove
Mackes, Claude B., 48 N. Main st., Woodstown
Miller, Lewis H., 37 S. Main st., Woodstown
Perry, Frank L., 43 East av., Woodstown
Prigger, Edward R., 39 W. Main st., Pennsgrove
Rankin, Stewart L., 61 S. River walk, Pennsgrove
Silverman, R. Louis, 3 Franklin st., Pennsgrove
Suter, Harry F., 49 W. Main st., Pennsgrove
Sutherland, Robert C., 95 S. Broad st., Pennsgrove
Thomas, Claude W., 28 East av., Woodstown
Weigel, Charles F. B., 328 E. Broadway, Salem
Zappala, John, 47 W. Main st., Pennsgrove

Number of Active Members and basis of representation, 28, March 15, 1939.

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June.

Active Members

Adams, Rayford K., Skillman
Albrecht, Wm. J., 25 N. Bridge st., Somerville
Ambrose, Robert R., Washington
Barbour, George E., 118 W. High st., Somerville
Beekman, John B., Bedminster
Bendix, Gerhard M., 4 W. Somerset st., Raritan
Blank, Sam'l, N. J. State Village Epileptics, Skillm'n
Borow, Benjamin, 574 Watchung av., Bound Brook
Borow, Henry, 507 Church st., Bound Brook
Borow, Louis S., 507 Church st., Bound Brook
Borow, Maurice, 509 Church st., Bound Brook
Brittain, Elmore G., 4 E. High st., Bound Brook
Cooley, Roger L., Dunellen
Cooper, J. Howard, East Millstone
Craig, Henry A., 315 William st., Somerville
Crawford, John W., Bedminster
Day, Hayward F., 37 Craig pl., N. Plainfield
Dundon, Arthur H., 135 Somerset st., N. Plainfield
Edelberg, Sidney S., 403 E. High st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
Falcone, Nicholas A., 68 Watchung av., N. Plainfield
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Flynn, Thomas H., 41 High st., Somerville
Fritts, Lewis C., 62 E. High st., Somerville
Gray, W. Burritt, 121 Somerset st., N. Plainfield
Greenberg, George A., 195 W. High st., Somerville
Guertin, Diomede, State Village, Skillman
Hamblin, Donald O., Calco Chemical Co., Bound Br'k
Hegeman, Runkle F., 161 W. High st., Somerville
Heminway, Norman L., Somerville
Hird, Emerson F., 118 E. Maple av., Bound Brook

Husted, Samuel H., Neshanic Station
Kay, C. Robert, Peapack
Klompus, Irving, 17 W. Union av., Bound Brook
Knight, Augustus S., Far Hills
Lawton, A. Anderson, 15 N. Bridge st., Somerville
Levy, Abram, Bound Brook
Long, William H., 40 S. Bridge st., Somerville
Mangelsdorff, Arthur F., Calco Chem. Co., B'd Brook
McConaughy, Francis, 1 E. High st., Somerville
Pigott, Albert W., Skillman
Pitman, Mason W. H., Bellemead
Pogoloff, Samuel H., Manville
Reale, Nicholas P., 119 S. Main st., Manville
Renner, Clara C., N. J. State Village, Skillman
Robinson, John T., 598 Watchung rd., Bound Brook
Russo, Dominick T., 51 E. Somerset st., Raritan
Scaccia, Alfred C., Bound Brook
Smalley, Mahlon C., Gladstone
Sokal, Henry B., Manville
Thomas, Mary L., Village for Epileptics, Skillman
Wallach, Bernard, 74 Watchung av., No. Plainfield
Wild, Frederick A., 111 E. High st., Bound Brook
Young, James L., 68 Mountain av., Somerville

Transferred

Douglass, Wm. C., from Morris Co. Medical Society
East, I. C., to Middlesex County Medical Society
Pearson, T. A., from Hunterdon Co. Medical Society
Shirlock, M. C., to Cumberland Co. Medical Society

Number of Active Members and basis of representation, 55, March 15, 1939.

SUSSEX COUNTY (19)

Society organized August 22, 1829. Meets at call of President. Annual Meeting on second Tuesday in May.

Active Members

Aitken, Herbert M., Ogdensburg
 Braun, David C., 216 Spring st., Newton
 Burn, Victor E., Newton
 Coleman, Joseph G., Hamburg
 Drake, Leo B., 47 Main st., Franklin
 Eddy, Lester R., 40 Bank st., Sussex
 Groeschel, August H., 31 Bank st., Sussex
 Johnson, George F., Branchville
 Kirschner, Martin I., Vernon
 Landes, Edwin W., Stillwater
 Longnecker, John E., Jr., Sparta
 Lushear, Frank H., Branchville
 McCall, Jesse, 12 Church st., Newton
 McVeigh, Charles J. D., Netcong

Morrison, Frederick H., Newton
 Pellet, Thomas L., Hamburg
 Roy, Bert W., 25 Hamburg av., Sussex
 Scott, Frederick J., 1 Oak st., Franklin
 Smith, Warren H., 91 Main st., Newton
 Spencer, James H., Jr., 23 Hospital rd., Franklin
 Spurgeon, Dorsett L., 19 Church st., Newton
 Vermes, Leslie, 172 Main st., Franklin

Transferred

Hawke, E. K., from Mercer County Medical Society
 Kaplan, Saul H., to out of state

Number of Active Members and basis of representation, 22, March 15, 1939.

UNION COUNTY (20)

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May. Annual Meeting in April.

Active Members

Abel, Henri E., 339 Union av., Elizabeth
 Abramson, Solomon, 1587 Irving st., Rahway
 Ackerman, Arthur F., 129 Summit av., Summit
 Armstrong, Lorrimer B., 121 S. Euclid av., Westfield
 Arthur, Frances H., 138 Westfield av., Elizabeth
 Austin, Thomas R., 19 Holly st., Cranford
 Babbitt, Hugh M., Jr., 101 W. 7th st., Plainfield
 Bailey, Harmon J., 116 Summit av., Summit
 Baker, Raymond DeW., 52 De Forest av., Summit
 Baron, Leo E., 727 N. Wood av., Linden
 Baruch, Rudolf J., 376 Elmora av., Elizabeth
 Beisler, Lawrence G., 1528 N. Broad st., Hillside
 Bensley, Maynard G., 129 Summit av., Summit
 Berenson, Samuel J., 1012 E. Jersey st., Elizabeth
 Berman, Leonard, 155 Summit av., Summit
 Berry, H. Clarence, 129 Summit av., Summit
 Birrell, Russell G., 554 Westminster av., Elizabeth
 Bishop, Carl, 831 Madison av., Plainfield
 Black, Max S., 1192 St. George av., Linden
 Blair, Thomas D., 414 Park av., Plainfield
 Bloch, Harry, 200 E. Jersey st., Elizabeth
 Blumberg, Jack, 504 Westminster av., Elizabeth
 Blythe, Rowland P., 30 Springfield av., Cranford
 Bolanowski, Kasimier J., 145 Marshall st., Elizabeth
 Booth, Walter S., 318 Grier av., Elizabeth
 Boozan, Wm. E., 1139 E. Jersey st., Elizabeth
 Bourns, Edward G., 126 Harrison av., Westfield
 Bowles, Harry H., 36 Woodland av., Summit
 Boyd, Robert P., 128 Second st., Fanwood
 Boyes, James G., 1326 Chetwynd av., Plainfield
 Brokaw, Chris. A., 1405 North av., Elizabeth
 Brown, L. Greeley, 173 Madison av., Elizabeth
 Brown, William H., 29 3rd st., Elizabeth
 Bunting, P. DuBois, 712 N. Broad st., Elizabeth
 Burritt, Norman W., 30 Beechwood rd., Summit
 Butenas, Jos. J., 300 1st av., Elizabeth
 Callahan, Edward J., 124 St. Paul st., Westfield
 Canright, Cyril M., 34 Springfield av., Cranford
 Card, Charles F., 100 W. Milton av., Rahway
 Carlisle, James M., Merck & Co., Rahway
 Carpenter, Cedric C., 129 Summit av., Summit
 Carsley, Sidney H., 19 Holly st., Cranford
 Casilli, Arturo R., 618 Newark av., Elizabeth
 Chapman, Otis P., 125 Broad st., Elizabeth
 Childers, Robert J., 604 Park av., Plainfield

Cole, Walter H., Jr., 116 Chilton st., Elizabeth
 Comunale, Anthony R., 1709 Irving st., Rahway
 Conway, Jas. V., 428 Elmora av., Elizabeth
 Corbusier, Harold D., 612 Park av., Plainfield
 Crabtree, Loren H., 142 Bellevue st., Elizabeth
 Crane, Norman T., 147 East 7th st., Plainfield
 Cronin, Francis J., 730 South st., Elizabeth
 Currie, Norman W., 508 Central av., Plainfield
 Dalberg, Walter, 757 N. Broad st., Elizabeth
 Davidson, E. Norwell, 102 E. Elm st., Linden
 Davidson, Maurice M., 128 Grant av. E., Roselle Pk.
 Davis, F. Cleveland, 129 Summit av., Summit
 Davis, Stanton H., 212 E. 7th st., Plainfield
 DeCesare, Ferdinand J., 500 Walnut st., Roselle Pk.
 Decker, Charles T., 275 Orchard st., Westfield
 DeFreitas, Clement, 423 W. 4th st., Plainfield
 Dengler, Henry P., 260 Morris av., Springfield
 Deutsch, Nathan S., 300 W. 7th st., Plainfield
 Disbrow, G. Ward, 126 Mountain av., Summit
 Doggett, Edwin H., 916 Park av., Plainfield
 Drury, Alfred J., 268 E. 3rd av., Roselle
 duBusc, L. C. Victor, 399 Westfield av., Elizabeth
 Dunn, H. Irving, 610 Salem av., Elizabeth
 Dwoyer, Leon C., 420 N. Wood av., Linden
 Edgar, Malcolm S., 129 Summit av., Summit
 Esty, Geoffrey, 629 East Broad st., Westfield
 Feleppa, Edward E., 239 Morris av., Summit
 Fitch, Thomas S. P., 916 Park av., Plainfield
 Fort, William B., 147 East 7th st., Plainfield
 Foster, Frank L., 320 Springfield av., Cranford
 Franklin, Jos. E., 127 Westfield av., Elizabeth
 Franklin, Lewis J., 618 Selfmaster Parkway, Union
 Freeman, Ray M., 826 N. Wood av., Linden
 Friedburg, Geo. H., 1108 Anna st., Elizabeth
 Frohwein, Ida H., 125 Morristown rd., Elizabeth
 Gadomski, Casimir F., 103 Murray st., Elizabeth
 Gallaway, George E., 163 W. Milton av., Rahway
 Gannon, Joseph M., 1137 Park av., Plainfield
 Geary, Paul, 923 Park av., Plainfield
 Gelber, Isaac, 2052 Morris av., Union
 Gerendasy, Julius, 956 E. Jersey st., Elizabeth
 Gibb, Alice S., 339 Union av., Elizabeth
 Giglio, Alphonsus S. V., 626 Elizabeth av., Elizabeth
 Gilpin, Fletcher, 118 North av. W., Cranford
 Gittelman, Morton, 426 Westminster av., Elizabeth
 Glaser, Emanuel, 360 Linden av., Elizabeth

Glass, Benjamin E., 609 Watchung av., Plainfield
Glass, Harry L., 923 Park av., Plainfield
Glassner, Frank, 308 Chestnut st., Roselle
Glasston, Hyman M., 628 N. Wood av., Linden
Golden, William M., 236 W. Milton av., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldgraben, Seymour, 407 Central av., Plainfield
Goldmacher, Herman B., 113 Elmora av., Elizabeth
Goldstein, Herman H., 318 W. Jersey st., Elizabeth
Gonczy, Edw. J., 538 Jersey av., Elizabeth
Grant, William E., 1939 Morris av., Union
Gregory, Roy A., 161 Crescent av., Plainfield
Griesemer, Z. Lawrence, 1143 E. Jersey st., Elizabeth
Griswold, Merton L., Jr., 949 Park av., Plainfield
Guidi, Guido M., 212 Christine st., Elizabeth
Hackett, Edw. J., 597 Westfield av., Westfield
Hall, Winthrop H., 400 Elm st., Westfield
Hallock, Wilton J., 650 Springfield av., Summit
Hansen, Harry 831 Madison av., Plainfield
Hanson, Carl G., 38 Springfield av., Cranford
Harrison, Joseph B., 302 E. Broad st., Westfield
Haseltine, Sherwin L., Hersh Tower Bldg., Elizabeth
Herrington, Lee R., 605 E. Broad st., Westfield
Hill, Clarence T., 43 E. Hazelwood av., Rahway
Hipple, Percy L., 230 Walnut st., Roselle
Hnat, Frederick, 624 Newark av., Elizabeth
Hoffman, Charles A., 302 E. 7th st., Plainfield
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holt, Evelyn, 261 Springfield av., Summit
Hoover, Alden R., 721 N. Broad st., Elizabeth
Horoschak, Anne, 974 Park av., Plainfield
Horre, George W. H., 203 W. Jersey st., Elizabeth
Hubbard, Harry V., 121 E. 7th st., Plainfield
Hughes, Frederic J., 706 Park av., Plainfield
Hunt, Thomas F., 528 Monroe av., Elizabeth
Huoni, John S., Sun Oil Co., Linden
Hutton, Frederick T., 1012 Park av., Plainfield
Imbleau, J. E. Lorrain, 2106 Morris av., Union
Jacobs, Alan L., 2130 Morris av., Union
Johnson, Harold F., 734 Park av., Plainfield
Jones, Herbert E., 612 Emerson av., Elizabeth
Jones, Lewis H., 139 E. Grant av., Roselle Park
Kaplan, Samuel D., 149 Bailey av., Hillside
Kapp, Carl G., 440 Westminster av., Elizabeth
Karshmer, Ernest E., 927 S. Wood av., Linden
Keeney, Caldwell B., 137 Summit av., Summit
Kemper, Harry T., 224 Monmouth rd., Elizabeth
Kinch, Frederick A., 267 E. Broad st., Westfield
Knauer, George, 930 Elizabeth av., Elizabeth
Knepper, Orcena F., 149 Crescent av., Plainfield
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 822 Park av., Plainfield
Krans, Clara DeH., 920 Park av., Plainfield
Krans, Edward S., 920 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kuchlewski, Edward J., 130 Third st., Elizabeth
Kushner, Alexander, 208 W. Milton av., Rahway
Labow, Joseph J., 1063 E. Jersey st., Elizabeth
Ladas, George, 305 Cherry st., Elizabeth
Laird, George S., 127 Central av., Westfield
Lance, Elton W., 125 W. Milton av., Rahway
Larrabee, Callie H., 14 Kent Place Blvd., Summit
Lathrop, Frederic W., 909 Park av., Plainfield
Laurie, Andrew L., 664 Newark av., Elizabeth
Lawrence, Wm. H., 129 Summit av., Summit
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield
Leggett, Thomas H., Jr., 937 Oakland pl., Plainfield
Lepree, Jos. A., 371 Morris av., Elizabeth
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lewis, Albert, 41 Retford av., Cranford
Lieberman, David P., 1063 North av., Elizabeth
Lieberman, Milton L., 101 Pershing av., Roselle Pk

Lippincott, Lansing Y., 1058 Kenyon av., Plainfield
Livengood, Horace R., 587 Westminster av., Elizabeth
Llull, Gabriel J., 266 Morris av., Springfield
Losada, Camella A., 19 Prospect st., Summit
Lowell, Milton E., 434 Summit av., Westfield
Lowenstein, Ernest C., 103 Elm av., Rahway
Lufburrow, Chas. B., 441 W. Front st., Plainfield
Lyerly, James M., 121 E. 7th st., Plainfield
Lynch, Edward T., 748 Livingston rd., Elizabeth
MacBrayer, Reuben A., 560 Morris av., Summit
Maggio, Ross J., 550 Carlton rd., Westfield
Malatesta, Chas. S., 302 E. 7th st., Plainfield
Marone, Carmine R., 648 1st av., Elizabeth
Maroney, James H., 129 Summit av., Summit
McClintock, Elsie, 1439 Maple av., Hillside
McGinn, Wm. J., 1913 Westfield av., Scotch Plains
Meeker, John L., 6 De Barry pl., Summit
Meineke, William C., Jr., 820 Chestnut st., Roselle
Merlo, Francis A., 210 Murray st., Elizabeth
Miller, Robt. M., 382 Springfield av., Summit
Milligan, Robert S., 259 Morris av., Summit
Mills, Stephen D., 132 S. Euclid av., Westfield
Minnella, Thos. J., 132 Morris av., Summit
Mohr, Frank L., 1030 Pine av., Union
Moister, Roger W., 7 Norwood av., Summit
Morris, Thos. M., 503 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Munger, Ray T., 727 Watchung av., Plainfield
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Newbury, Graham C., 209 Holly st., Cranford
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
Novello, Joseph A., 641 Second av., Elizabeth
Nussbaum, Joseph, 321 Elmora av., Elizabeth
Obester, Gabriel E., 646 Madison av., Elizabeth
Oderr, Charles, 659 Glen av., Westfield
Orton, Foster, 196 Elm av., Rahway
Orton, George L., 196 Elm av., Rahway
Osher, Morris M., 194 Martine av., N. Fanwood
Owen, Philip, 1273 Stuyvesant av., Union
Paulson, Arch. M., 160 E. 7th st., Plainfield
Pearl, Sydney S., 545 Rahway av., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Phelan, Walter F., 124 Chilton st., Elizabeth
Poleshuck, Rubin, 127 Hollywood av., Hillside
Prout, Thos. P., 19 Prospect st., Summit
Read, Jessie D., 519 Lenox av., Westfield
Reich, Jerome J., 1410 Maple av., Hillside
Reiner, Jacob, 811 N. Broad st., Elizabeth
Relyea, George McD., 129 Summit av., Summit
Ripps, Maurice L., 410 Elmora av., Elizabeth
Roberts, Ebdon G., 1115 St. George av., Roselle
Robertson, Grace M., 650 W. 7th st., Plainfield
Rosenstein, Saivel L., 2120 Springfield av., Vauxhall
Runnells, John E., Bonnie Burn Sana., Scotch Plains
Sadoff, Joseph, 116 Elmora av., Elizabeth
Salvati, Leo H., 244 Walnut st., Westfield
Samuels, Sol L., 219 W. 7th st., Plainfield
Satulsky, Emanuel M., 652 Park av., Elizabeth
Schenk, Jos. R., 1177 Park av., Plainfield
Schiller, Edwin, 449 Westminster av., Elizabeth
Schiller, Rosa O., 449 Westminster av., Elizabeth
Schilling, Anthony B., 727 Jefferson av., Elizabeth
Schlein, David, 26 Price st. E., Linden
Schlichter, Chas. H., 556 N. Broad st., Elizabeth
Schwartz, Samuel H., 1044 Park av., Plainfield
Sell, Frederick W., 167 W. Emerson av., Rahway
Senerchia, Fred F., Jr., 604 Westminster av., Eliza.
Seybold, Arthur D., 302 E. 7th st., Plainfield
Seymour, George A., 253 Orchard st., Elizabeth
Shangle, Milton A., 34 Prince st., Elizabeth
Sherman, Samuel H., 81 Elmora av., Elizabeth
Shirrefs, Russell A., 348 Elmora av., Elizabeth

Sims, Richard V., Jr., 21 Morris av., Summit
 Singer, Bella, 406 Elmora av., Elizabeth
 Sly, John L., 382 Springfield av., Summit
 Spirito, Michael W., 1071 Elizabeth av., Elizabeth
 Spivack, David, 944 E. Jersey st., Elizabeth
 Stanton, Nathaniel B., 734 Park av., Plainfield
 Staub, E. Milton, 531 E. Broad st., Westfield
 Steele, Stephen, 10 West Gibbons st., Linden
 Stein, Emil, 607 Park av., Elizabeth
 Stein, George H., 406 Elmora av., Elizabeth
 Stein, Isadore, 210 Elizabeth av., Elizabeth
 Stein, Martin H., 60 Elmora av., Elizabeth
 Steinberg, Werner, 45 E. Henry st., Linden
 Stephenson, Gordon A., 145 Summit av., Summit
 Steuart, David F. R., 11 De Barry pl., Summit
 Stillwell, Harry C., 51 W. Milton av., Rahway
 Strelinger, Alexander, 650 N. Broad st., Elizabeth
 Strom, Abraham, 410 W. 7th st., Plainfield
 Stuart, James E., 552 E. 2nd st., Plainfield
 Suffness, Gustave, 1087 E. Jersey st., Elizabeth
 Taranto, Michael, 635 N. Wood av., Linden
 Tator, Arthur E., 57 DeForest av., Summit
 Terrell, Edward E., 110 Alden st., Cranford
 Tidaback, John D., 382 Springfield av., Summit
 Townsend, Leslie M., 37 Grant av. E., Roselle Park
 Triarsi, Anthony J., 702 Third av., Elizabeth
 Tyndall, Alice E., 329 Mountain av., Westfield
 Tyndall, Martha W., 329 Mountain av., Westfield
 Vinciguerra, Michael, 604 Westminster av., Elizabeth
 Vitale, Dominic V., 681 Newark av., Elizabeth
 Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
 Wacker, William F., 1224 Salem av., Hillside
 Wade, Simon F., 555 Newark av., Elizabeth
 Wagner, Otto, 111 Stiles st., Elizabeth
 Wagner, Richard, 43 S. Broad st., Elizabeth
 Walsh, Ronald J., 118 E. 5th av., Roselle

Walsh, Thomas J., 335 S. Broad st., Elizabeth
 Ward, Leo J., 137 W. Jersey st., Elizabeth
 Warncke, Frank H., 523 Westfield av., Elizabeth
 Webb, Eleanor A., 30 Elm st., Summit
 Wegryn, Louis S., 257 Elizabeth av., Elizabeth
 Weigel, Edgar W., 970 Park av., Elizabeth
 Weigel, Elmer P., 727 Watchung av., Plainfield
 Western, Frederic B., 1227 Morris av., Townley
 Williams, Frank A., 324 W. Jersey st., Elizabeth
 Williams, Leonard D., 518 Park av., Plainfield
 Wolff, Jerome M., 1414 Martine av., Plainfield
 Wolgin, Philip L., 445 Elmora av., Elizabeth
 Woody, McIver, 454 Union av., Elizabeth
 Wuester, William O., Eliza. Gen. Hosp., Elizabeth
 Yood, Raphael, 401 Grant av., Plainfield
 Young, Franklin C., 120 Summit av., Summit
 Yuckman, Robert O., 224 W. Jersey st., Elizabeth
 Yuckman, William, 701 Madison av., Elizabeth
 Zeitlin, Herman H., 943 N. Wood av., Linden

Resigned

Krans, Clara DeH., Plainfield
 Turner, William F., Cranford

Transferred

Franklin, Lewis J., from Missouri
 Bruning, Richard H., to Essex County Medical Soc.
 Disler, Louis S., to Hudson County Medical Society
 Moress, Edward J., to Essex County Medical Soc.
 Orris, Harold J., to Essex County Medical Society
 Shack, Maxwell H., to Essex County Medical Soc.
 Liana, Stephen M., to Passaic County Medical Soc.

Number of Active Members and basis of representation, 202, March 15, 1939.

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

Active Members

Baldauf, Herman, Jr., Front st., Belvidere
 Bloom, Lawrence H., 8 Market st., Phillipsburg
 Bossard, Harry B., R. D. No. 2, Phillipsburg
 Bostwick, Wallace R., Main st., Blairstown
 Brasefield, Edgar N., 218 Chamber st., Phillipsburg
 Buchanan, Ralph McK., 131 S. Main st., Phillipsb'g
 Cummins, George W., 202 Mansfield st., Belvidere
 *Curtis, Frank W., Stewartsville
 Drake, Paul F., 85 Summit av., Phillipsburg
 Dresel, Irmgard, Far Hills
 Hackett, Leon W., 173 Belvidere av., Washington
 Kassow, Philip B., North Blvd., Alpha
 Krausz, Emery, 577 S. Main st., Phillipsburg
 Marlett, Neumann C., 311 Front st., Belvidere

McMurtrie, William A., Far Hills
 Potter, C., Belvidere av., Washington
 Pursell, William D., 508 S. Main st., Phillipsburg
 Shimer, Floyd A., 88 Lewis st., Phillipsburg
 Smith, Herman, Phillipsburg
 Smith, J. Meredith, 212 Grand av., Hackettstown
 Spillane, Timothy H. P., 379 S. Main st., Phillipsb'g
 Vail, William P., Blairstown
 Varney, William H., 122 Belvidere av., Washington
 West, Guernsey F., 109 So. Main st., Phillipsburg
 Wing, Raymond, Blair Academy, Blairstown
 Wolf, Frank A., 494 S. Main st., Phillipsburg
 Zuck, Arthur C., 22 Broad st., Washington

Number of Active Members and basis of representation, 27, March 15, 1939.

NUMBER OF MEMBERS ON THE OFFICIAL LIST, MARCH 15, 1939

	Active Members	Associate Members			
Atlantic	116	1	Salem	28	
Bergen	201	18	Somerset	55	
Burlington	53		Sussex	22	
Camden	183		Union	292	
Cape May	26		Warren	27	
Cumberland	55		Total	3473	139
Essex	942	53			
Gloucester	45				
Hudson	432				
Hunterdon	27				
Mercer	223	23			
Middlesex	123	25			
Monmouth	126				
Morris	107				
Ocean	27				
Passaic	363	19			

SUMMARY

	March 15, 1938	March 15, 1939
Active	3335	3473
Associate	149	139
Total	3484	3612
Increase in Number of Members		128
Deaths of Members During the Year		42

MEETINGS OF THE COUNTY SOCIETIES

Atlantic County.—Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in May.

Bergen County.—Meets on second Tuesday each month except July and August. Annual Meeting in May.

Burlington County.—Meets second Thursday evening of each month except June, July and August. Annual Meeting in May.

Camden County.—Meets first Tuesday in each month, October to May inclusive, with an outing in June. Annual Meeting in May.

Cape May County.—Four regular meetings each year. Meets on first Tuesday in April and October. Annual Meeting in November. Semi-annual meeting in April. Other two meetings at call of the President.

Cumberland County.—Meets on the second Tuesday in October, December, February, April and June. Annual Meeting in April.

Essex County.—Meets second Thursday of each month, October to May, inclusive. Annual Meeting second Thursday in May.

Gloucester County.—Regular meetings on the third Thursday of each month except June, July and August. Annual Meeting in May. Annual Social Session in October.

Hudson County.—Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, the meeting is held on the next day. Annual Meeting in May.

Hunterdon County.—Meets on the fourth Tuesday of January, April, July and October, April being the Annual Meeting.

Mercer County.—Meets on the second Wednesday of each month, except July, August and September, at 8:30 p.m., in the Trenton Country Club. Annual Meeting in December. Annual Banquet in November.

Middlesex County.—Meets on third Wednesday of each month, October to June inclusive. Annual Meeting in December.

Monmouth County.—Meets on the fourth Wednesday in each month from October to June, inclusive. Annual Meeting in April.

Morris County.—Meets on the third Thursday in each month from October to June, inclusive. Annual Meeting in June.

Ocean County.—Meets on second Wednesday of each month except June, July, August and September. Annual Meeting in May.

Passaic County.—Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in May.

Salem County.—Meets on the second Friday of each month, September to May inclusive. Annual Meeting in April. Social Meeting in May.

Somerset County.—Meets on the second Thursday evening of each month except July, August and September. Annual Meeting in June.

Sussex County.—Meets at call of President. Annual Meeting on second Tuesday in May.

Union County.—Meets second Wednesday of September, November, January, March, April, and May. Annual Meeting in April.

Warren County.—Meets on third Tuesday of January, April, July and October, the last named being the Annual Meeting.

An Alphabetical List of the Members of the Medical Society of New Jersey

COMPILED MARCH 15, 1939

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

*Deceased.

ACTIVE MEMBERS

- Abel, Arthur R., 144 Harrison st., East Orange (7)
 Abel, Henri E., 339 Union av., Elizabeth (20)
 Abell, Elvira D., R. F. D. No. 2, Morristown (14)
 Abey, Wm. J. H., 21 E. Delaware av., Pen'gton (11)
 Abrams, Abram B., 299 Clinton av., Newark (7)
 Abramson, Solomon, 1587 Irving st., Rahway (20)
 Ackerman, Arthur F., 129 Summit av., Summit (20)
 Ackermann, Edward, 5 Richards av., Dover (14)
 Ackley, David B., 21 N. Clinton av., Trenton (11)
 Adams, Geo. B. McC., 304 Monm'th st., Gloucester (4)
 Adams, Rayford K., Village for Epil'pt's, Skillm'n (18)
 Adelman, Benjamin B., 190 Clinton av., Newark (7)
 Adler, Joseph, 933 Ave. C, Bayonne (9)
 Africano, Julius V., 4242 Hudson Blvd., Union C'y (9)
 Agnew, Hobart McV., 144 S. Harrison st., E. Orange (7)
 Agolia, Michael W., 441 Palisade av., Union City (9)
 Ainsley, H. Bryson, 246 Union st., Jersey City (9)
 Aitken, Frank J., 20 N. Pearl st., Bridgeton (6)
 Aitken, Herbert MacG., Ogdensburg (19)
 Albano, Edwin H., 242 Clifton av., Newark (7)
 Albano, Joseph, 535 N. 7th st., Newark (7)
 Albrecht, Wm. J., 25 N. Bridge st., Somerville (18)
 Albright, Louis F., 118 Madison av., Spring Lake (13)
 Alcamo, John H., 215 Littleton av., Newark (7)
 Alford, Ralph I., 83 Park st., Montclair (7)
 Allaben, Anna L., 165 South st., Morristown (14)
 Allan, James S., 144 Harrison st., East Orange (7)
 Allen, Arthur A., 365 Park av., Paterson (16)
 Allen, Chester B., Jr., 254 Midland av., Montclair (7)
 Allen, G. Herbert, 181 Roseville av., Newark (7)
 Allen, Isaac L., 521 Palisade av., Union City (9)
 Allen, James M., 657 Main av., Passaic (16)
 Alling, Frederic A., 15 Washington st., Newark (7)
 Allman, David B., 104 St. Charles pl., Atlantic C'y (1)
 Alpert, Edward, 661 Jersey av., Jersey City (9)
 Alter, Nicholas M., 410 Fairmount av., Jersey C'y (9)
 Altman, Charles D., 301 Highland av., Newark (7)
 Altschul, Frank J., 177 Garf'ld av., Long Branch (13)
 Ambrose, Anthony, 71 Congress st., Newark (7)
 Ambrose, Robert R., Washington (18)
 Amdur, Louis A., 2540 Boulevard, Jersey City (9)
 Anderson, John F., 195 College av., New Bruns. (12)
 Anderson, Reuben M., 408 Main st., Hackens'k (2)
 Anderson, Richard D., 465 High st., Burlington (3)
 Anderson, Robert C., 519 Sanford av., Newark (7)
 Anderson, Wm. M., 20 Kings Hwy. W., Haddonf'd (4)
 Andrae, Paul, 52 Warner av., Jersey City (9)
 Andrews, Clarence L., 1616 Pacific av., Atl. City. (1)
 Andrus, David L., 805 Cooper st., Camden (4)
 Angelillo, Marc C., 169 Bloomfield av., Newark (7)
 Angelo, Joseph A., 10 Centre av., Secaucus (9)
 Anthony, David W., 201 Withersp'n st., Pr'nc't'n (11)
 Antonius, Nicholas A., 27 W. Market st., Newark (7)
 Antopol, Wm. A., 201 Lyons av., Newark (7)
 Anuario, Chas. B., 283 S. Centre st., Orange (7)
 Apgar, Francis A., Oldwick (10)
 Applebaum, Irving L., 152 Clinton av., Newark (7)
 Applegate, Edw. T. R., 1125 Greenw'd av., Tr'nt'n (11)
 Applestein, Robert, 568 E. State st., Trenton (11)
 Appold, Geo. D., 60 E. Church st., Bergenfield (2)
 Apter, Abraham H., 528 E. 29th st., Paterson (16)
 Arbeit, Sidney R., 2521 Boulevard, Jersey City (9)
 Areson, Wm. H., 153 Bellevue av., Up. Montclair (7)
 Aria, Michael H., 31 Glenwood av., Jersey City (9)
 Armstrong, Lorrimer B., 121 S. Euclid av., W'st'f'd (20)
 Armstrong, Robt. R., 114 Pennington av., Passaic (16)
 Arndt, Frank R., 960 Bergenline av., N. Bergen (9)
 Aronis, Harry R., 239 E. Hanover st., Trenton (11)
 Arthur, Frances H., 138 Westfield av., Elizabeth (20)
 Asbell, Nathan, 328 Cooper st., Camden (4)
 Ash, Arthur F., 710 Boulevard, E., Weehawken (9)
 Ash, Frank W., 180 Carroll st., Paterson (16)
 Ash, Samuel, 25 Johnson av., Newark (7)
 Asher, Maurice, 186 Clinton av., Newark (7)
 Ashley, Harmon H., 192 W. State st., Trenton (11)
 Assante, Mario H., Evesham av., Magnolia (4)
 Aszody, Paul, 340 Waverly av., Newark (7)
 Athey, Kenneth L., 3616 Westfield av., Camden (4)
 Atkinson, J. M., 93 Greenwood av., Madison (14)
 Atkinson, James W., 603 S. Maple av., Glen Rock (16)
 Atwell, David R., 920 Hudson st., Hoboken (9)
 Atwood, Edward A., 360 Park av., Paterson (16)
 Auriemma, Michele, 419 Adams st., Hoboken (9)
 Austin, Thomas R., 19 Holly st., Cranford (20)
 Averbach, Jacob, 435 Clifton av., Clifton (16)
 Avery, Philip S., Mid'l's'x Gen. Hosp., New Bruns. (12)
 Avidan, Maurice S., 30 Stratford pl., Newark (7)
 Axford, Wm. H., Chester (9)

ASSOCIATE MEMBERS

- Abrams, Henry, 195 Nassau st., Princeton (11)
 Alpren, Bernard F., 34 Auburn st., Paterson (16)
 Andrick, Eugene A., Hohokus (2)

ACTIVE MEMBERS

- Babbitt, Hugh M., Jr., 101 W. 7th st., Plainfield (20)
 Bachmann, Wm., 87 Hillcrest ter., East Orange (7)
 Bacon, Mary, 278 E. Commerce st., Bridgeton (6)
 Bacote, Ernest F., 78 Barclay st., Newark (7)
 Baeseman, R. Winfield, 501 Grand av., Asb'p'k (13)
 Bagg, Linus W., 31 Lincoln Park, Newark (7)
 Bahnson, Conrad M., 170 Bowers st., Jersey C'y (9)
 Bailey, Chas. P., Box 89, M st., W. Belmar (13)
 Bailey, Harmon J., 116 Summit av., Summit (20)
 Baily, Emanuel, 331 16th st., West New York (9)
 Baiocchi, Pascal J., 203 Hunterdon st., Newark (7)
 Baird, Thompson M., 124 Grand pl., Arlington (7)
 Baker, Augustus L., 389 W. Blackwell st., Dover (14)

- Baker, Banks S., 601 Walnut st., Camden (4)
 Baker, Charles F., 198 Clinton av., Newark (7)
 Baker, Clifford, 800 Elm st., Vineland (6)
 Baker, Elsworth F., State Hospital, Marlboro (13)
 Baker, Hugh W., 8th & Elmer sts., Vineland (6)
 Baker, Maclyn M., 638 Stuyvesant av., Irvington (7)
 Baker, Maurice E., 1149 Kaighn av., Camden (4)
 Baker, Philip W., High Bridge (10)
 Baker, Raymond D., 52 DeForest av., Summit (20)
 Baketel, H. Sheridan, 155 VanWagenen av., Jer.C'y (2)
 Baldauf, Herman, Jr., Front st., Belvidere (21)
 Baldwin, Samuel H., 626 Clinton av., Newark (7)
 Ballinger, Reeve L., 659 Kearny av., Arlington (9)
 Balze, Henry R., 147 Christie st., Leonia (2)
 Banks, Winifred D., 6 N. Munn av., E. Orange (7)
 Barb, Kirk B., 1303 Princess av., Camden (4)
 Barbarito, Wm. N., 135 Bentley av., Jersey City (9)
 Barbash, Samuel, 1902 Pacific av., Atlantic City (1)
 Barbour, George E., 118 W. High st., Somerville (18)
 Barishaw, Samuel B., 5 Bentley av., Jersey City (9)
 Barkhorn, Charles W., 223 Roseville av., Newark (7)
 Barkhorn, Henry C., 45 Johnson av., Newark (7)
 Barlow, Frank A., 965 Madison av., Paterson (16)
 Barlow, G. Barton, 157 Engle st., Englewood (2)
 Barnard, Frank G., 22 Plymouth st., Montclair (7)
 Barnes, William J., 155 Engle st., Englewood (2)
 Barnshaw, Harold D., 406 Cooper st., Camden (4)
 Barolsky, Benjamin, 306 Broadway, Paterson (16)
 Baron, Leo E., 727 N. Wood av., Linden (20)
 Barr, Joseph, 975 Madison av., Paterson (16)
 Barrett, Arthur F., 835 Montgomery st., Jer.C'y (9)
 Barrett, John E., 635 Summer av., Newark (7)
 Barrett, Joseph F., 230 Parker av., Maplewood (7)
 Barroway, James N., 2626 Federal st., Camden (4)
 Barrows, Arthur M., 440 Hamilton av., Trenton (11)
 Barrows, Victor I., 316 N. Broadway, Pitman (8)
 Barry, Rolla G., 908 W. State st., Trenton (11)
 Bartlett, Clara K., 4301 Atlantic av., Atlantic C'y (1)
 Baruch, Rudolf J., 376 Elmora av., Elizabeth (20)
 Bass, Rose D., 54 Lyons av., Newark (7)
 Bassett, Lavern C., 320 New Market rd., Dunell'n (12)
 Bassett, Norman H., 1616 Pacific av., Atl. City (1)
 Baum, Felix, 765 S. 10th st., Newark (7)
 Baum, Samuel, 10 Osborne ter., Newark (7)
 Bauman, Everett O., 17 Hillside av., Newark (7)
 Bauman, Rush C., 92 High st., Nutley (7)
 Bayne, Joseph K., 12 Princeton av., Princeton (11)
 Beairsto, Everett B., 178 W. State st., Trenton (11)
 Beaver, Jennie D., 44 Elm st., Morristown (14)
 Becker, Charles F., 620 Benson st., Camden (4)
 Becker, Frederick W., 14 Clinton pl., Newark (7)
 Becker, George L., 646 E. 28th st., Paterson (16)
 Becker, Leo V., 69 Ward st., Paterson (16)
 Becker, Martin, 351 Halsted st., East Orange (7)
 Becker, Sidney D., 140 Maple pl., Keyport (13)
 Becket, George C., 350 Springdale av., E.Orange (7)
 Beekman, John B., Bedminster (18)
 Behrens, Herman H. E., 312 Webster av., Jer.C'y (9)
 Beideman, Casper M., 5 W. Maple av., Merch'tv'le (4)
 Beir, Ily R., 114 S. Virginia av., Atlantic City (1)
 Beisler, Lawrence G., 1528 N. Broad st., Hillside (20)
 Belafsky, Henry A., 150 Greene st., W'dbridge (12)
 Belfer, Jacob J., 1235 Chambers st., Trenton (11)
 Belford, Ralph J., 90 Nassau st., Princeton (11)
 Beling, C. Abbott, 111 Clinton av., Newark (7)
 Beling, Christopher C., 111 Clinton av., Newark (7)
 Bell, Horace O., Essex Co. Hosp., Belleville (7)
 Bell, Thomas, 340 Belmont av., Newark (7)
 Bellak, Ellis R., Leesburg (6)
 Bellis, Horace D., 437 E. State st., Trenton (11)
 Belting, Arthur W., 836 W. State st., Trenton (11)
 Ben-Asher, Solomon, 260 Bergen av., Jersey City (9)
 Bender, Theodore, 666 Broadway, Paterson (16)
 Bendix, Gerhard, 4 W. Somerset st., Raritan (18)
 Benedict, Alfred C., 121 Irvington av., S. Orange (7)
 Benjamin, Harold C., 59 Crescent av., Jersey City (9)
 Benjamin, Joseph F., 203 Godwin av., Ridgewood (16)
 Bennett, Samuel D., 118 Pine st., Millville (6)
 Bennett, Wm. F., Essex Mt. Sanatorium, Verona (7)
 Bensley, Maynard G., 129 Summit av., Summit (20)
 Bentley, David F., Jr., 406 Cooper st., Camden (4)
 Berardinelli, Carmine G., 92 8th av., Newark (7)
 Berenson, Sam'l J., 1012 E. Jersey st., Elizabeth (20)
 Berg, Samuel, 156 Roseville av., Newark (7)
 Berger, Harry, 921 S. Clinton av., Trenton (11)
 Berger, Wm. A., 346 Roseville av., Newark (7)
 Bergin, Joseph V., 315 Broadway, Paterson (16)
 Bergman, Meyer W., 31 Lincoln Park, Newark (7)
 Bergmeyer, Josef T., 422 20th st., W. New York (9)
 Berk, M. David, 33 Bartholf av., Pompton Lks. (16)
 Berke, Raynold N., 430 Union st., Hackensack (2)
 Berkhout, Peter G., 106 Haledon av., Prosp't P'k (16)
 Berkow, Samuel G., 138 Market st., P. Amboy (12)
 Berkowitz, Benjamin, 20 Bank st., Bridgeton (6)
 Berlin, Joseph I., 2600 Hudson Blvd., Jersey City (9)
 Berman, H. Robert, 286 Roseville av., Newark (7)
 Berman, Jacob J., 409 Market st., Trenton (11)
 Berman, Leonard M., 155 Summit av., Summit (20)
 Bernard, Richard C., 248 State st., Hackensack (2)
 Bernhard, Wm. G., Countryside dr., Murray Hill (7)
 Bernheisel, Louis E., Reading av., Tuckahoe (5)
 Bernstein, Arthur, 330 Belmont av., Newark (7)
 Berry, Hartley C., 129 Summit av., Summit (20)
 Bertha, Nicholas A., 275 S. Main st., Wharton (14)
 Beshlian, Hagop K., 7 Lee pl., Paterson (16)
 Betancourt, Raul R., 406 Cooper st., Camden (4)
 Betcher, Albert M., 21 Highland av., Jersey City (9)
 Betts, R. Winfield, 22 N. Main st., Medford (3)
 Beveridge, Wm. W., 1000 Grand av., Asbury P'k (13)
 Beyer, Othmer J., 42 Laurel av., Irvington (7)
 Bianchi, Angelo R., 184 Hunterdon st., Newark (7)
 Biczak, Arkad K., 311 Lexington av., Clifton (16)
 Bien, Frank A., 999 Clinton av., Irvington (7)
 Bierach, Jules L., 106 Washington st., Toms River (15)
 Bigelow, Elizabeth F., 120 Prospect st., S.Orange (7)
 Bigelow, Nelson S., 120 Prospect st., S. Orange (7)
 Bigliani, Urban R., 526 36th st., North Bergen (9)
 Binder, Joseph, 101 Third av., Long Branch (13)
 Bingham, Arthur W., 144 Harrison st., E.Orange (7)
 Bird, Frank L., Main st., Netcong (14)
 Birdsall, Clarence A., 9 Small av., Caldwell (7)
 Birely, Morris F., 170 E. Ridgew'd av., Ridgew'd (16)
 Birrell, Russell G., 554 Westminster av., Elizab'h (20)
 Bishop, Carl, 831 Madison av., Plainfield (20)
 Bissett, John V., 29 Hawthorne av., East Orange (7)
 Bitten, Robt. M., 33 Romaine av., Jersey City (9)
 Biunno, Anthony J., 53 Finlay pl., Newark (7)
 Black, Max, 1192 St. George av., Linden (20)
 Blackburne, George, 490 Central av., Newark (7)
 Blackwell, Enoch, 28 W. State st., Trenton (11)
 Blair, Thomas D., 414 Park av., Plainfield (20)
 Blaisdell, C. Byron, 489 Broadway, Long Branch (13)
 Blake, Roger N., 729 Kinderkam'k rd., River Edge (2)
 Blakey, Abram Post, 155 Wegman Pkwy., Jer.C'y (9)
 Blanchard, Charles L., 28 E. Blackwell st., Dover (14)
 Blanchard, Kenneth, 25 S. Munn av., E. Orange (7)
 Blank, Sam'l, N. J. St. Vil. Epileptics, Skillman (11)
 Blaugrund, Samuel, 190 W. State st., Trenton (11)
 Blaustein, Maurice L., 37 Hillside av., Newark (7)
 Blauvelt, Grace B., 76 Heights rd., Ridgewood (2)
 Blauvelt, Harold, 46 Parker av., Maplewood (7)
 Bleasby, Charles B., 136 Passaic st., Garfield (2)
 Bleiberg, Jacob, 565 Bergen st., Newark (7)
 Bleick, Theodore E., 61 Van Ness pl., Newark (7)
 Bleick, Wm. D., 583 Prospect st., Maplewood (7)
 Bleier, Louis, 239 Lafayette st., Newark (7)
 Blenkle, Victor A., 140 Chadwick rd., Teaneck (2)
 Bloch, Harry, 200 E. Jersey st., Elizabeth (20)

- Block, Marcus T., 177 Bloomfield av., Newark (7)
 Block, Max, 48 N. Fullerton av., Montclair (7)
 Block, Milton, 711 Chancellor av., Irvington (7)
 Bloom, Lawrence H., 8 Market st., Phillipsburg (21)
 Blum, Joseph M., 128 Mill st., Trenton (11)
 Blumberg, A. William, New Egypt (15)
 Blumberg, Jack, 504 Westminster av., Elizabeth (20)
 Blythe, Rowland P., 30 Springfield av., Cranford (20)
 Bobadilla-Riquelme, Juan E., 27 E. Bl'kw'll st., D'v'r (14)
 Bocchini, Joseph A., 366 S. 12th st., Newark (7)
 Bohl, Louis J., 320 Broadway, Paterson (16)
 Bokor, Emery, 819 S. 12th st., Newark (7)
 Boland, Lucy E., 27 Washington st., Arlington (9)
 Bolanowski, Kasimier J., 145 Marshall st., Eliz'b'h (20)
 Bolton, Bernard, 291 Osborne ter., Newark (7)
 Bonanno, Peter J., 500 35th st., North Bergen (9)
 Bongiorno, Henry D., 516 River st., Paterson (16)
 Bono, Joseph J., Paris av., Northvale (2)
 Bonyng, Henry A., 123 Prospect st., Ridgewood (16)
 Bookstaver, Barnett S., 193 Norma rd., Teaneck (2)
 Bookrajan, Edward N., 5459 Boulevard, N. Bergen (9)
 Booth, George R., 219 Highland av., Westville (8)
 Booth, Walter S., 318 Grier av., Elizabeth (20)
 Booth, William K., 304 William st., Boonton (14)
 Boothby, I. Roland, Clinton (10)
 Boozan, Wm. E., 1139 E. Jersey st., Elizabeth (20)
 Bornstein, David, 80 Carroll st., Paterson (16)
 Bornstein, Paul K., 415 S. Lake dr., Belmar (13)
 Borow, Benjamin, 574 Watchung av., Bound Br'k (18)
 Borow, Henry, 507 Church st., Bound Brook (18)
 Borow, Louis S., 507 Church st., Bound Brook (18)
 Borow, Maurice, 509 Church st., Bound Brook (18)
 Borrella, Dominic D., 476 Hamilton av., Trenton (11)
 Borrone, Milton G., 2695 Boulevard, Jersey City (9)
 Borshaw, Hyman, 108 Bentley av., Jersey City (9)
 Borsher, Irving P., 249 Broad st., Bloomfield (7)
 Bortone, Frank, 2765 Boulevard, Jersey City (9)
 Boselli, Emile H., 614 15th st., Union City (9)
 Bossard, Harry B., R. D. No. 2, Phillipsburg (21)
 Bossert, Chas. L., 4021 Atlantic av., Atlantic City (1)
 Bostwick, Delazon S., Cumber'd Hotel, Bridgeton (6)
 Bostwick, Wallace R., Main st., Blairstown (21)
 Botbyl, Burt W., 927 Madison av., Paterson (16)
 Botti, John A., 236 Summit av., Jersey City (9)
 Bove, Joseph, 306 Lincoln av., Orange (7)
 Bourns, Edward G., 126 Harrison av., Westfield (20)
 Bowers, F. Clyde, Mountain av., Mendham (14)
 Bowels, Harry H., 36 Woodland av., Summit (20)
 Bowersox, Clarence A., 106 S. Cl'mbia av., W'db'ry (8)
 Bowyer, Franklin F., 50 Gifford av., Jersey City (9)
 Boyd, John B., 141 Broad st., Red Bank (13)
 Boyd, Robert P., 128 Second st., Fanwood (20)
 Boyer, Charles G., Annandale (10)
 Boyes, James G., 1326 Chetwynd av., Plainfield (20)
 Boylan, Lawrence B., 630 Main st., Paterson (16)
 Boysen, Theo. H., 100 Philad'lphia st., Egg Hrbr. C'y (1)
 Brackett, Elizabeth R., 371 Franklin av., Nutley (7)
 Bradford, Stella S., 16 Seymour st., Montclair (7)
 Bradley, Robert A., 1616 Pacific av., Atlantic City (1)
 Bradshaw, John H., 27 High st., Orange (7)
 Brady, Thomas S., 678 Ave. C. Bayonne (9)
 Braitman, Max, 412 16th st., West New York (9)
 Brakeley, Elizabeth, 71 Myrtle av., Montclair (7)
 Bramble, Halsey S., Front & Chestnut sts., Elmer (17)
 Brams, William M., 7 Madison av., Newark (7)
 Brancato, Peter, 17 Church st., Paterson (16)
 Brandman, Otto, 83 Johnson av., Newark (7)
 Branch, Wm. H., 190 Duncan av., Jersey City (9)
 Branin, Howard S., 200 W. Main st., Millville (6)
 Brasefield, Edgar N., 218 Chamber st., Phil'psb'g (21)
 Brauer, Selig L., 234 Bergen av., Jersey City (9)
 Braun, David C., 216 Spring st., Newton (19)
 Braun, Gustav A., 221 S. Orange av., Newark (7)
 Braun, Wm., 4307 W. Maple av., Merchantville (4)
 Braunstein, Sigmund C., 424 13th st., W. NewY'k (9)
 Braunstein, Wm. P., 1 Bellevue st., Weeh'wk'n (9)
 Bray, William E., 41 Elizabeth st., Pemberton (3)
 Bregman, Alexander, 2 Dempsey av., Edgewater (2)
 Brennan, Charles L. S., 14 S. Br'dw'y, Glouc'str C'y (4)
 Brennan, John P., 429 Cooper st., Camden (4)
 Brennock, Thos. McG., 3 Webster av., Jersey C'y (9)
 Breslow, Samuel, 157 Market st., Perth Amboy (12)
 Brewer, William, 34 Cooper st., Woodbury (8)
 Brevoort, Henry H., 54 Main st., Lodi (16)
 Brick, George J., 43 Cottage st., Jersey City (9)
 Brien, William M., 449 Main st., Orange (7)
 Briggs, Henry, 144 Harrison st., East Orange (7)
 Brim, Anne J. S., Hotel Edgemere, E. Orange (7)
 Brindle, Harry R., 501 Grand av., Asbury Park (13)
 Brittain, Elmore G., 4 E. High st., Bound Brook (18)
 Broadnax, Mary E., 140 Roseville av., Newark (7)
 Brod'k'n, Eva T., 365 Osborne ter., Newark (7)
 Brod'k'n, Henry A., 365 Osborne ter., Newark (7)
 Brody, Morton S., 75 Livingst'n av., NewBrun's (12)
 Brogan, Francis B., 84 Ward st., Paterson (16)
 Brokaw, Christopher A., 1405 North av., Eliz'b'h (20)
 Bromberg, Chas. B., 107 Lexington av., Passaic (16)
 Brooks, George M., Cape May Court House (5)
 Brooks, Sidney, 62 12th av., Paterson (16)
 Brophy, Francis X., 55 Gifford av., Jersey City (9)
 Brotman, Morton M., 90 Avon av., Newark (7)
 Brown, Chester R., 22 Midland av., Arlington (7)
 Brown, Chester T., Prudential Ins. Co., Newark (7)
 Brown, Fred'k L., 67 L'v'gst'n av., NewBrunsw'k (12)
 Brown, Harvey S., 5 Claf pl., Freehold (13)
 Brown, Harold W., 27 S. Fullerton av., Montclair (7)
 Brown, J. Carlisle, 101 S. Indiana av., Atl. City (1)
 Brown, John L., 647 Anderson av., Grantwood (2)
 Brown, Kenneth G., 501 Grand av., Asbury Park (13)
 Brown, L. Greeley, 173 Madison av., Elizabeth (20)
 Brown, Lewis W., 160 Roseville av., Newark (7)
 Brown, Richard J., 105 Ridgewood rd., S. Orange (7)
 Brown, Stanley L., Glen av. & Loc'st st., L'rel Spr'gs (4)
 Brown, Wm. H., 29 Third st., Elizabeth (20)
 Browning, W. Kempton, 120 N. Centre st., M'rch'tv'le (4)
 Browning, Wm. J., 134 N. Centre st., Merch'tv'le (4)
 Brozdowski, John J., 554½ Jersey av., Jersey C'y (9)
 Bruder, Andrew J., 344 Fairmount av., Jer. City (9)
 Buchanan, Ralph McK., 131 S. Main st., Phil'psb'g (21)
 Buckley, J. L., 666 Franklin av., Nutley (7)
 Buckley, Paul J., 159 Palisade av., Bogota (2)
 Buckley, Rich'd T., Jr., Peddie Sch'l, Hightst'w (11)
 Budd, J. Reuben, 379 Clifton av., Clifton (16)
 Budington, Walter L., 24 Commerce st., Newark (7)
 Buermann, Robert, 206 Madison av., Lakewood (15)
 Bugbee, Frederick C., 132 Sunset av., Verona (7)
 Bull, Louis M., 92 Heller Parkway, Newark (7)
 Bull, Robert I., 361 Lafayette st., Newark (7)
 Bull, William J., 98 Park st., Montclair (7)
 Bullen, Victor E., 148 Hamilton av., Paterson (16)
 Bullwinkel, Fred'k, Oc'n Blvd. & 4th av., At. H'hl'ds (13)
 Bunnell, Fred'k N., 22 S. Main st., Barnegat (15)
 Bunting, P. DuBois, 712 N. Broad st., Elizabeth (20)
 Burbidge, J. Raym'd, Is'bella McCosh Inf., Pr'net'n (11)
 Burke, Leonard P., 30 Lakeside av., Verona (7)
 Burke, Stephen E., 212 First av., Newark (7)
 Burkett, J. Paul, 215 Delaware st., Woodbury (8)
 Burkett, Wendell J., 16 W. Holly av., Pitman (8)
 Burn, Victor E., 27 Trinity st., Newton (19)
 Burne, John J., 17 Gould av., Newark (7)
 Burnett, Chas. B., 109 Main st., South River (12)
 Burnham, Lyman, 229 Engle st., Englewood (2)
 Burns, Edward L., 269 Broad st., Newark (7)
 Burns, Geoffrey C. H., County rd. & So. st., Demarest (2)
 Burns, Joseph R., 46 S. Olden av., Trenton (11)
 Burns, Wilmer F., 267 White Horse Pike, Audubon (4)
 Burpeau, Wm. P., 144 Harrison st., E. Orange (7)
 Burritt, Norman W., 30 Beechwood rd., Summit (20)

Burroughs, Edmund W., 701 W.State st.,Trenton(11)
Burstein, Frank, 402 Clinton av., Newark (7)
Busansky, Samuel T., Circle drive, Browns Mills (3)
Busch, Herman, 38 Johnson av., Newark (7)
Bush, Archer C., 40 Union st., Montclair (7)
Bush, Ralph K., 131 E. Park av., Merchantville (4)
Busico, Philip S., 131 Liberty rd., Englewood (2)
Butcher, Charles, Heislerville (6)
Butenas, Joseph J., 300 First av., Elizabeth (20)
Butler, Eustace C., 249 Bloomfield av., Caldwell (7)
Butler, Vincent P., 33 Bentley av., Jersey City (9)
Butterfield, Arey A., 135 Aycrigg av., Passaic (16)
Buvinger, Chas. W., 50 Washington st., E.Orange(7)
Buzby, B. Franklin, 414 Cooper st., Camden (4)
Byck, Lou's, 114 Lyons av., Newark (7)
Byer, M. Yale, 827 E. State st., Trenton (11)
Byers, Clarence W., 176 Union av., Rutherford (2)
Byrne, James A., 181 South st., Morristown (14)

ASSOCIATE MEMBERS

Balles, Edward S., 295 Broadway, Paterson (16)
Bancone, Albina V., 545 N. 7th st., Newark (7)
Banta, Raymond E., 118 E. Clinton av., Tenaflly (2)
Bernson, Samuel T., 653 S. 18th st., Newark (7)
Besson, Franklin J., 999 Clinton av., Irvington (7)
Bowman, Ned O., 1001 Georges rd.,NewBrunsw'k(12)
Brown, Leonard, Hackensack Hosp., Hackensack(2)
Burrill, Benjamin B., Jr., Pmptn. av.,PmptnPls.(16)
Byrnes, Elizabeth W., 142 Clinton av., Newark (7)
Bythewood, Alton E., Jr., 145 W. Market st.,Nwk.(7)

ACTIVE MEMBERS

Cacciarelli, Robt. A., 517 Roseville av., Newark (7)
Caggiano, Anthony P., 237 Grove st., Montclair (7)
Caggiano, John D., 165 W. Main st., Pennsgrove(17)
Cahill, Laurence A., 361 Lafayette st., Newark (7)
Calasibetta, Chas. J., 37 Longfellow av., Newark (7)
Caldroney, Thos. L., 66 Bergen av., Ridgef'd P'k(2)
Caldwell, Donald M., Prudential Ins. Co., Newark(7)
Caldwell, Julius A., 45 S. Mountain av.,Montclair(7)
Callahan, Edward J., 124 St. Paul st., Westfield(20)
Callery, Wm. T., 10 Columbia ter., Weehawken (9)
Calligaro, Egildo A., 75 Clifton av., Clifton (16)
Calvert, Wm. C., 225 Gregory av., W. Orange (7)
Calvin, Chas. H., 80 Commerce st., Perth Amboy(12)
Camche, Leo J., 250 Renner av., Newark (7)
Cameron, C. Paul, 401 Atlantic av., Ocean City (5)
Cameron, Edwin A., 186 S. Burnett st., E. Orange(7)
Campbell, James M., 101 S. Central av., Ramsey (2)
Campbell, William, 144 Harrison st., East Orange(7)
Campbell, Wm. K., 96 Third av., Long Branch (13)
Candio, Vincent P., 347 Ridge rd., Lyndhurst (2)
Cannon, Edward A., 5360 Hudson Blvd.,N.Bergen(9)
Canright, Cyril M., 34 Springfield av., Cranford (20)
Caputo, Anthony R., 217 Belleville av., Belleville(7)
Carabelli, A. Albert, 306 Hamilton av., Trenton (11)
Carberry, Edward T., 67 S. Main st., Wharton (14)
Carbone, Francesco N., 157Hunterdon st.,Newark(7)
Card, Chas. F., 100 W. Milton av., Rahway (20)
Cardwell, Edgar P., 47 Central av., Newark (7)
Carey, David S., 11 E. Main st., Freehold (13)
Caridi, Salvatore, 465 Bergenline av.,W.NewYork(9)
Carlander, Oswald R.,1972Br'wning rd.,M'rch'tv'le(4)
Carlisle, James M., Merck & Co., Rahway (20)
Carlisle, John H., 129 Prospect st., Passaic (16)
Carlough, David J., 426 Ell'son st., Paterson (16)
Carman, Fletcher F., 31 Lincoln Park, Newark (7)
Carmona, L. Roberto, 141 Wood st., Tuckerton (15)
Carpenter, Cedric C., 129 Summit av., Summit (20)
Carpenter, Wm. H., 39 Aberdeen pl., Woodbury (8)
Carr, Mary B., 1 Astor pl., Jersey City (9)
Carrigan, Francis P., 516 Prospect st., Maplew'd(7)

Carrington, Wm. J., 905 Pacific av., Atlantic C'y(1)
Carrol, Wilfred, 56 Goodwin av., Newark (7)
Carroll, C. Walter, 117 Centre st., Trenton (11)
Carroll, William V., 211 Academy st., Trenton (11)
Carsley, Sidney H., 19 Holly st., Cranford (20)
Carter, Joseph F. S., 142 Atkins av., Asbury P'k(13)
Cartnick, Louis C., 228 Hillcrest av., W'd Ridge (2)
Casale, John B., 359 Bloomfield av., Newark (7)
Casilli, Arturo R., 618 Newark av., Elizabeth (20)
Casselman, Arthur J., 301 N. 2nd st., Camden (4)
Catanzaro, Francesco, 151 Jefferson st., Passaic (16)
Cater, Douglas A., 57 S. Harrison st., E. Orange (7)
Cella, Charles F., 335 Hamilton av., Trenton (11)
Cerone, Daniel M., 309 First av., Newark (7)
Cestone, Canio, 521 Pompton av., Cedar Grove (7)
Chalfant, W. Paxson,Jr.,7003Ventnor av.,Ventnor(1)
Chamberlain, Aims R., 30 Lenox pl., Maplewood (7)
Chamberlain, Richard R., 30 Lenox pl., Maplew'd (7)
Champlin, Paul M., 43 S. Arlington av., E.Orange(7)
Chapman, Ellis J., 203 Danforth av., Jersey City (9)
Chapman, Otis P., 125 Broad st., Elizabeth (20)
Chapman, Robert W., 835 Bergen st., Newark (7)
Chapnick, Maurice M., 117 Paterson st.,Paters'n(16)
Charlton, C. Coulter, 124 S. Illinois av.,Atl.City(1)
Chase, Kalman, 591 N. Maple av., Hohokus (2)
Chase, William E., 137 Gregory av., Passaic (16)
Chayes, Sydney, 980 Ave. C, Bayonne (9)
Cherashore, Harry N., 363 Centre st., Nutley (7)
Cherry, Homer H., Valley View Sana.,Paterson(16)
Chesner, Wm. A., 1111 Hamilton av., Trenton (11)
Chesler, Maurice, 124 W. Broadway, Salem (17)
Chester, Saul W., 634 Broadway, Paterson (16)
Chew, Elisha C., 603 Pacific av., Atlantic City (1)
Chianese, C. Chester, 464 Hamilton av., Trenton(11)
Chiger, Alexander S., 621 High st., Newark (7)
Childers, Robert J., 604 Park av., Plainfield (20)
Chilton, Forrest S., Pompton Plains (16)
Chimacoff, Hyman, 171 Elizabeth av., Newark (7)
Chimley, Bascomb L., Valley ViewSana.,Paterson(16)
Chmelnik, Abraham G., 299 Clinton av., Newark(7)
Chrisman, Irving, 408 Ellison st., Paterson (16)
Christensen, Alexander H., Lebanon (10)
Christian, Henry A., 111 Fairview av., Jer. City (9)
Church, Franklin H., 86 W. Broadway, Salem (17)
Ciampa, Ralph P. E., 383 Bath av., Long Branch(13)
Ciicone, Anthony C., 389 Grand st., Paterson (16)
Cieri, Daniel S., 315 Central av., Union City (9)
Ciliberti, Frank J., Jr., 713 S. 5th st., Camden (4)
Clarie, D'Arcy C., 558 Broad av., Ridgefield (2)
Clark, Alice L., 206 W. State st., Trenton (11)
Clark, Charles C., 461 New York av., Union City(9)
Clark, Chas. E., N. J. State Hospital, Trenton (11)
Clark, Ernest W., 209 Haddon av., Westmont (4)
Clark, Frank G., White House Station (10)
Clark, John C., 404 Asbury av., Asbury Park (13)
Clark, J. Henry, 108 Orange rd., Montclair (7)
Clark, S. Worth, 152 S. No. Carolina av.,Atl.C'y(1)
Clarke, Edw. W., 435 Warwick av., W. Englew'd(2)
Clarke, Francis M., 116 New st., New Brunsw'k (12)
Clarcken, Joseph A., 43 Lincoln Park, Newark (7)
Claus, C. Hermann, 776 S. 19th st., Newark (7)
Clay, Thomas A., 351 Totowa av., Paterson (16)
Clayton, John C., 73 W. Main st., Freehold (13)
Cleary, Joseph P., Minotola (1)
Clement, Baxter L., 31 Lincoln Park, Newark (7)
Clement, Lavinia B., 124KingsHghwy.W.,H'dnfd(4)
Clinton, Joseph A., 339 Park av., Newark (7)
Clippinger, Richard D., 220 S. West av., Vineland(6)
Close, Byron H., Hamburg Tnpk., Bloomingdale(16)
Closson, Edward W., 2 Main st., Lambertville (10)
Cloud, Albert W., Huguenot av., Englewood (2)
Cobham, James L., 78 Brinkerhoff st., Jer. City (9)
Cochrane, Cleland D., Main st., Closter (2)
Coe, Richard, 156 Clinton av., Newark (7)

- Coffin, Henry F., 433 Mt. Prospect av., Newark (7)
 Cogan, Henry, 128 Carroll st., Paterson (16)
 Coghlan, Jasper, 540 Parker st., Newark (7)
 Cohan, Charles C., 217 W. Hanover st., Trenton (11)
 Cohen, Herman, 489 Jersey av., Jersey City (9)
 Cohen, Herman, 1301 Hamilton av., Trenton (11)
 Cohen, Herman N., 714 Park av., Hoboken (9)
 Cohen, I. Elvin, 561 Elizabeth av., Newark (7)
 Cohen, Julian, 475 Park av., Paterson (16)
 Cohen, Louis, 257 Paulison av., Passaic (16)
 Cohen, Maurice, 106 Valley rd., Montclair (7)
 Cohen, Max, 60 Ridge rd., N. Arlington (7)
 Cohen, Meyer J., 118 Johnson av., Newark (7)
 Cohen, M. Marvin, 137 Graham av., Paterson (16)
 Cohen, Nathan B., 232 State st., Perth Amboy (12)
 Cohen, Oscar H., 115 Church st., Boonton (14)
 Cohen, Paul, 218 State st., Camden (4)
 Cohen, Samuel, 28 Duncan av., Jersey City (9)
 Cohen, Samuel A., 112 Mercer st., Jersey City (9)
 Cohen, Sidney A., 283 Clinton av., Newark (7)
 Cohen, Sidney L., 20 Avon av., Newark (7)
 Cohen, Sidney P., 512 Franklin av., Nutley (7)
 Cohen, William, 1007 Greenwood av., Trenton (11)
 Cohn, Hermann, 393 Clinton av., Newark (7)
 Cohn, Isidor, 231 Lexington av., Passaic (16)
 Cohn, Royal M., 740 Clinton av., Newark (7)
 Colby, Maxwell X., 287 Westw'd av., L'ng Branch (13)
 Cole, Lewis F., 242 Broadway, Passaic (16)
 Cole, Walter H., Jr., 116 Chilton st., Elizabeth (20)
 Coleman, Austin H., Clinton (10)
 Coleman, Joseph G., Hamburg (19)
 Collier, Martin H., Camden Co. T.B. Hosp., Gr'n'l'ch (4)
 Collier, Wm. S., 1000 S. Broad st., Trenton (11)
 Collins, Henry J., 1160 Hamilton av., Trenton (11)
 Collins, Laurence M., Greystone Park (14)
 Collins, Louis K., 54 State st., Glassboro (8)
 Colmer, Meyer J., 31 Lincoln Park, Newark (7)
 Colsh, LeRoy L., 612 Ridgewood rd., Maplewood (7)
 Colton, Ethan T., Jr., 31 Park st., Montclair (7)
 Comando, Harry N., 690 Clinton av., Newark (7)
 Comeau, George W., 415 Speedwell av., Morris Pls. (14)
 Comfort, John B., 50 S. Clinton av., Trenton (11)
 Comora, Herman C., 317 16th st., W. New York (9)
 Comunale, Anthony R., 1709 Irving st., Rahway (20)
 Conaway, Walt P., 1723 Pacific av., Atlantic City (1)
 Condon, John F., 686 Mt. Prospect av., Newark (7)
 Conlon, Philip J., 25 James st., Newark (7)
 Connamacher, Harold S., 671 Springf'd av., N'w'rk (7)
 Connell, Emmet J., 2227 Boulevard, Jersey City (9)
 Connell, John N., 26 Carlton av., Jersey City (9)
 Connolly, John A., 212 W. State st., Trenton (11)
 Connolly, John J., 180 Ballantine Pkwy., Newark (7)
 Connolly, Richard N., City Hospital, Newark (7)
 Connolly, Thomas V., 56 Hamilton st., Paterson (16)
 Connolly, Thos. W., 921 Bergen av., Jersey City (9)
 Connor, Clarence A., 1586 Center av., Fort Lee (2)
 Conroy, John S., 122 E. Broad st., Burlington (3)
 Conty, Anthony J., 318 48th st., Union City (9)
 Conway, James V., 428 Elmora av., Elizabeth (20)
 Cook, Hugh F., 21 Roseville av., Newark (7)
 Cooke, H. Hamilton, 100 Prospect st., Ridgew'd (2)
 Cooke, Wm. H., 303 Main st., East Orange (7)
 Cooley, Roger L., Dunellen (18)
 Cooper, Howard M., 37 Ridge rd., Rutherford (2)
 Cooper, Irving J., 116 Livingston av., NewBrun. (12)
 Cooper, J. Howard, East Millstone (18)
 Cooperman, William, 647 Market st., Newark (7)
 Copleman, Hyman B., 50 Liv'gst'n av., N'wBrun. (12)
 Coppola, Edward A., 22 Garretsee pl., Clifton (16)
 Coppoletta, Joseph M., 452 Palisade av., Cliff. P'k (2)
 Corbusier, Harold D., 614 Park av., Plainfield (20)
 Corio, George A., 307 S. Clinton av., Trenton (11)
 Cornish, Chas. H., 673 Prospect st., Maplewood (7)
 Cornwell, Alfred, 265 N. Laurel st., Bridgeton (6)
 Corpening, Flave H., Park av., Laurel Springs (4)
 Corrigan, Patrick H., 1720 S. Broad st., Trenton (11)
 Corson, Allen, 824 Wesley av., Ocean City (5)
 Corson, Elton S., 133 E. Commerce st., Bridgeton (6)
 Corson, Filbert R., 101 S. Indiana av., Atlantic C'y (1)
 Corson, Kenneth E., 25 S. Myrtle st., Vineland (6)
 Cortese, Alvin E., 26 Ward st., Paterson (16)
 Cosgrove, Samuel A., 254 Union st., Jersey City (9)
 Costello, Wm. F., 55 W. Blackwell st., Dover (14)
 Cotton, Henry A., Jr., 192 W. State st., Trenton (11)
 Cotton, Norman T., 219 Graham av., Paterson (16)
 Cottone, Rosario J., 683 Princeton av., Trenton (11)
 Cottrell, Judson G., 159 Market st., Perth Amboy (12)
 Coughlan, Ella A., 10 Oakwood av., Orange (7)
 Coughlin, Frank J., 100 Magnolia av., Arlington (7)
 Coughlin, John P., 160 Wegman Parkway, Jer. C'y (9)
 Coultas, Aldo B., 1 Madison av., Madison (14)
 Cowbeck, Harry D., 224 W. State st., Trenton (11)
 Cox, Harold C., 208 Stockton st., Hightstown (11)
 Cox, John C., 55 Woodland rd., Maplewood (7)
 Cox, John R., 37 W. Main st., Pennsgrove (17)
 Cox, Wm. W., 79 S. Fullerton av., Montclair (7)
 Coxson, Harold P., Laurel rd., Stratford (4)
 Crabtree, Loren H., 142 Bellevue st., Elizabeth (20)
 Cracco, Frederick A., 51 Palisade av., Union City (9)
 Craig, Henry A., 315 William st., Somerville (18)
 Craig, Wm. C., 235 E. Ridgewood av., Ridgewood (2)
 Crain, William E., 43 Curtis av., Woodbury (8)
 Crandall, John K., 200 Main st., Fort Lee (2)
 Crandell, C. Archie, N.J. State Hosp., Greyst'ne P'k (14)
 Crane, Bernard, 306 Pacific av., Atlantic City (1)
 Crane, Charles G., 78 Farley av., Newark (7)
 Crane, Norman T., 147 E. 7th st., Plainfield (20)
 Crapanzano, Domenica, Essex Co. Hosp., Cedar Gr. (7)
 Craster, Chas. V., Plane & William sts., Newark (7)
 Crawford, Georgina U., 28 Carnegie av., E. Orange (7)
 Crawford, John W., Main st., Bedminster (18)
 Crecca, William D., 111 Park av., Newark (7)
 Cregar, John S., 160 Harrison st., East Orange (7)
 Cremens, John F., 144 Carroll st., Paterson (16)
 Crescente, Fred J., 827 Madison av., Paterson (16)
 Crist, Walter A., 725 Collings av., W. Collingsw'd (4)
 Cronin, Francis J., 730 South st., Elizabeth (20)
 Cropsey, Chas. D., 168 Chestnut st., Rutherford (2)
 Crossfield, Henry C., 144 Harrison st., E. Orange (7)
 Crounse, David R., 84 Broadway, Passaic (16)
 Crowe, Aldrich C., 735 Atlantic av., Ocean City (5)
 Crowley, Joseph W., 4005 Westfield av., Camden (4)
 Crowley, Leo F., 148 Belmont av., Jersey City (9)
 Cryder, Millard C., Cape May Court House (5)
 Crystell, Edward H., 4 Hawthorne av., Nutley (7)
 Csema, Emery J., 151 Somerset st., NewBrun. (12)
 Culver, George M., 25 Glenwood av., Jersey City (9)
 Culver, Samuel H., 75 Magnolia av., Jersey City (9)
 Cummins, George W., 202 Mansfield st., Belvidere (21)
 Cunningham, Chas., 75 Wood st., Vineland (6)
 Cunningham, Joel B., 31 N. Main st., Pennington (11)
 Currie, Norman W., 508 Central av., Plainfield (20)
 Curry, Marcus A., Greystone Park (14)
 Curtis, Austin M., Jr., 445 Van Hout'n st., P'trs'n (16)
 Curtis, Donald A., 241 Union st., Hackensack (2)
 Curtis, Elbert A., 65 Central av., Newark (7)
 *Curtis, Frank W., Stewartsville (21)
 Curtis, Grant P., 312 36th st., Union City (9)
 Curtis, Howard C., 129 Chester av., Moorestown (3)

ASSOCIATE MEMBERS

- Carbone, Ralph, Hackensack (2)
 Colavita, James J., 433 Princeton av., Trenton (11)
 Commini, Frank F., 217 Hamilton av., Trenton (11)
 Cott, Abe A., 730 Prospect st., Maplewood (7)
 Coughlin, Joseph J., Ridgefield Park (2)
 Cuono, Joseph D., 276 E. 19th st., Paterson (16)

ACTIVE MEMBERS

- D'Acerno, Pellegrino A., 346 P'lis'de av., Union C'y (9)
D'Addario, Anthony R., 108 Broadway, Newark (7)
D'Agostin, Henry, 243 Fulton ter., Cliffside (2)
D'Agostini, Alfred J., 41 Columbia av., Newark (7)
Dalberg, Walter, 757 N. Broad st., Elizabeth (20)
Dalton, Simon E., 117 S. Illinois av., Atlantic City (1)
Daly, Edmund J., 921 Bergen av., Jersey City (9)
Dandois, George F., 220 E. Wildwood av., Wildw'd (5)
Dane, Charles, 61 Scotland rd., South Orange (7)
Dane, John, 61 Scotland rd., South Orange (7)
D'Angelo, Joseph C., 330 Washingt'n av., Belleville (7)
Danielson, John J., 977 Bergen Tnpk., N. Bergen (9)
Danzis, Maximillian, 31 Lincoln Park, Newark (7)
D'Arcy, Walter E., 545 E. State st., Trenton (11)
Darden, Walter T., 149 W. Kinney st., Newark (7)
Darlington, Emlen P., New Lisbon (3)
Davenport, Irwin P., 194 W. State st., Trenton (11)
Davenport, Peter B., 764 S. Orange av., Newark (7)
Davey, Thomas N., 41 W. 33rd st., Bayonne (9)
Davidson, E. Norwell, 102 E. Elm st., Linden (20)
Davidson, Harold S., 101 S. Indiana av., Atl. City (1)
Davidson, Henry A., 31 Lincoln Park, Newark (7)
Davidson, Louis L., 31 Lincoln Park, Newark (7)
Davidson, Maurice M., 128 E. Grant av., Ros'le P'k (20)
Davies, George A., 53 Front st., Elmer (6)
Davies, George W., 35 Fairview av., Verona (7)
Davis, A. Hobson, Paterson Gen. Hosp., Paterson (16)
Davis, Albert B., 511 Cooper st., Camden (4)
Davis, Elbert V., Vincentown (3)
Davis, F. Cleveland, 129 Summit av., Summit (20)
Davis, Harold L., 178 W. State st., Trenton (11)
Davis, Jacob M., 1400 High st., Burlington (3)
Davis, John E., Jr., N. J. State Hosp., Trenton (11)
Davis, Louis, 825 S. 10th st., Newark (7)
Davis, Stanton H., 212 E. 7th st., Plainfield (20)
Davis, Thomas C., 30 Old Short Hills rd., Millburn (7)
Davis, W. Cole, 109 S. Portland av., Ventnor (1)
Davison, C. Spencer, 7 Chestnut st., Salem (17)
Davison, Royden W., 205 W. State st., Trenton (11)
Davison, Wilbur S., Pittsf'd st. & S'I'm rd., P'nsv'le (17)
Dawson, Harry, 618 E. 24th st., Paterson (16)
Day, Grafton E., Frazer & N. J. avs., Collingsw'd (4)
Day, Hayward F., 37 Craig pl., N. Plainfield (18)
Day, Samuel T., Main st., Port Norris (6)
Dean, Guy K., Jr., Plainsboro rd., Princeton (11)
Deary, Louis E., 88 W. 39th st., Bayonne (9)
DeBell, Peter J., 239 Burgess pl., Passaic (16)
DeBiao, Cornelius V., 9 W. Park pl., Rutherford (2)
DeCesare, Ferdinand J., 500 Walnut st., Ros'le P'k (20)
Decker, Charles T., 275 Orchard st., Westfield (20)
Decker, Frederick H., Frenchtown (10)
Decker, Henry B., 527 Penn st., Camden (4)
DeFreitas, Clement, 423 W. 4th st., Plainfield (20)
DeFronzo, Morando, 180 Fairmount av., Newark (7)
DeFuccio, Chas. P., 12 Duncan av., Jersey City (9)
DeFusco, G. Thos., 330 Newark av., Jersey City (9)
Degenhardt, Ira H., 51 Livingston av., NewBrun. (12)
DeGrace, Francis H., 344 Gregory av., Passaic (16)
deHellebranth, Roland T., 104 S. Fr'kft av., V'ntn'r (1)
Deibert, Irvin E., 618 Benson st., Camden (4)
Deibert, Kirk R., 159 Elm av., Woodlynne (4)
Deich, Samuel R., 162 Lexington av., Passaic (16)
Deichman, Chas. H., 39 Elm st., Morristown (14)
Deignan, William L., 257 Dodd st., E. Orange (7)
Deitz, Joseph R., 320 Centre st., Trenton (11)
Delario, Anthony J., 294 Broadway, Paterson (16)
Del Deo, Nicholas V., 49 State st., Newark (7)
Del Duca, Vincent P., 406 Cooper st., Camden (4)
Del Guercio, Olindo, 365 Bloomfield av., Newark (7)
Della Fera, Lucien F., 206 First av., Newark (7)
Del Mauro, Alphonse, 417 21st av., Paterson (16)
Demarest, J. Willis, 124 Elm av., Hackensack (2)
De Mattia, Michael, 71 Ward st., Paterson (16)
Dembinski, T. Henry, 1238 S. Clinton av., Trenton (11)
DeMeritt, Chas. L., 1225 Bloomfield st., Hoboken (9)
De Michele, Roland V., 359 Clifton av., Newark (7)
Dempsey, J. Harvey, Washington av., Berlin (4)
Denbo, Elic A., 854 Haddon av., Camden (4)
Denelsbeck, Julius O., 878 E. State st., Trenton (11)
Denes, Oscar, 402 Centre av., Nutley (7)
Dengler, Henry P., 260 Morris av., Springfield (20)
DePalma, Anthony F., 242 Clifton av., Newark (7)
dePons, Isabel S. C., 501 Grand av., Asbury Park (13)
DeRosa, Armand, 290 Union Blvd., Totowa Bor'gh (16)
DeRosa, John, 150 Fair st., Paterson (16)
Dershimer, Fred'k W., 546 Bergen av., Jersey C'y (9)
DeSanto, Anthony M., 377 Essex st., Hackensack (2)
Desmet, Victor F., 324 Broadway, Paterson (16)
De Troia, Frederick C., 40 12th av., Newark (7)
Deutel, Oscar R., 283 Franklin st., Bloomfield (7)
Deutsch, Nathan S., 223 E. 5th st., Plainfield (20)
De Vincentis, Henry, 285 Henry st., Orange (7)
Dev'l'n, Frank, 617 Broadway, Newark (7)
Devlin, Hugh J., 72 Thomas st., Newark (7)
Dewis, Edwin G., 21 Westra st., Interlaken (13)
De Yoe, Leon E., 602 Broadway, Paterson (16)
Dexter, Harriet E. T., 903 Ave. C, Bayonne (9)
Dezer, Chas. N., Jr., 210 Main st., Hackensack (2)
Diamond, David I., Oceanport av., Oceanport (13)
Dias, Joseph L., 17 Lombardy st., Newark (7)
Dickson, John D., 202 Larch av., Bogota (2)
Dickson, T. Bruce, 408 Main st., Riverton (3)
Dieffenbach, Richard H., 570 Mt. Pr'sp't av., Nwk. (7)
Dieker, Howard E., 78 Main st., South River (12)
DiGiacomo, Wm. H., 223 Fairmount av., Newark (7)
Dilger, Frederick G., 210 Main st., Hackensack (2)
Dillingham, Willis I., 431 15th st., W. New York (9)
Dimun, John T., 960 S. Broad st., Trenton (11)
Dinge, Ferdinand C., 67 S. Munn av., E. Orange (7)
Dingman, Norman M., 330 Broadway, Paterson (16)
D'Nicolantonio, Vincent J., 1902 Pacific av., Atl. C'y (1)
Di Norcia, Joseph, 357 Third av., Newark (7)
Disbrow, G. Ward, 126 Mountain av., Summit (20)
Diskan, Samuel M., 1904 Pacific av., Atlantic City (1)
Diverty, Henry B., 38 Cooper st., Woodbury (8)
Dodd, Edward L., 157 Forest st., Belleville (7)
Dodd, Wm. E., Ocean st. & Bay av., Beach Haven (15)
Dodson, Louis W., 592 Jersey av., Jersey City (9)
Doggett, Edwin H., 916 Park av., Plainfield (20)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Donahue, William J., 71 S. 9th st., Newark (7)
Donnelly, Joseph E., 451 Market st., Paterson (16)
Donnelly, Jos. P., 58 Kensington av., Jersey City (9)
Donohoe, Lucius F., 140 W. Eighth st., Bayonne (9)
Donovan, Jos., N. J. State Hosp., Greystone P'k (14)
Doody, Wm. M., 19 Bentley av., Jersey City (9)
Doran, Ralph J., 200 11th st., Hoboken (9)
Doran, Wm. G., 921 Bergen av., Jersey City (9)
Doranz, Harold K., 491 Centre st., Trenton (11)
Doremus, Widmer E., 375 Mt. Prospect av., Nwk. (7)
Dorn, Elliott I., 267 Vassar av., Newark (7)
Dougherty, Daniel D., 1006 Garden st., Hoboken (9)
Douglass, Stephen A., Valley View Sana., Paters'n (16)
Dow, Robert F., 272 Park av., Paterson (16)
Dowd, Ambrose F., 239 Broadway, Newark (7)
Downing, Perley E., Sedgwick av., Jamesburg (12)
*Downs, Elwood E., 7 S. Childs st., Woodbury (8)
Downs, Louis S., 141 Roosevelt av., Carteret (12)
Downs, Roscius I., 40 Scott st., Riverside (3)
Draesel, Chas., 5681 Hudson Blvd., N. Bergen (9)
Dragonetti, Elvige N., 177 Clifton av., Newark (7)
Drake, Daniel E., Union Valley rd., Newfound'nd (16)
Drake, Leo B., 47 Main st., Franklin (19)
Drake, Paul F., 85 Summit av., Phillipsburg (21)
Dranow, Paul, 233 Franklin av., Nutley (7)
Drapkin, Berta, 31 Lincoln Park, Newark (7)
Dresel, Irmgard, Far Hills (21)

- Dreskin, Jacob L., 172 Lyons av., Newark (7)
 Drezner, Henry L., 507 S. Warren st., Trenton (11)
 Driscoll, Chas. D., Gr'nt st. & Wt. Hrs. Pk., W. Clgswd. (4)
 Driscoll, Raymond S., 919 Hudson Blvd., Bayonne (9)
 Drury, Alfred J., 268 E. Third av., Roselle (20)
 DuBois, Morris G., 769 High st., Newark (7)
 duBuse, Lawrence C. V., 399 Westf'd av., Elizab'h (20)
 Duckett, Warren J., 21 Carlton av., Jersey City (9)
 Dukes, Howard R., 220 Kearny av., Kearny (9)
 Dulin, Everett V., 144 Harrison st., E. Orange (7)
 Duncan, Owsley B., 606 E. 26th st., Paterson (16)
 Dundon, Arthur H., 135 Somerset st., N. Plainf'd (18)
 Dunn, H. Irving, 610 Salem av., Elizabeth (20)
 Dunn, John S., 75 Market st., Salem (17)
 Dunn, Theodore B., 395 Franklin st., Bloomf'd (7)
 Dunning, Walter L., 533 River st., Paterson (16)
 Durham, Royal E., 130 S. Illinois av., Atlantic C'y (1)
 Dwyer, Leon C., 420 N. Wood av., Linden (20)
 Dwyer, Henry E., 261 Madison av., Passaic (16)
 Dwyer, Wm. A., 99 Park av., Paterson (16)
 Dyer, Edward H., 102 S. Victoria av., Ventnor (1)

ASSOCIATE MEMBERS

- D'Alessandro, Arthur J., 94 Boylan st., Newark (7)
 Della Penna, Sam'l J., 502 Ramapo av., Pmpth. Lks. (16)
 Del Negro, Albert E., 402 Roseville av., Newark (7)
 De Phillips, Benedict R., 43 Park av., Newark (7)
 Dodge, James T., 1819 S. Broad st., Trenton (11)
 Dunham, Malcolm M., 88 Grove av., Woodbridge (12)
 Durchlag, E. Nelson, 12 Myrtle av., Irvington (7)

ACTIVE MEMBERS

- Eagleton, Wells P., 15 Lombardy st., Newark (7)
 Eames, Wm. N., 1871 Pennington rd., Trenton (11)
 Earp, Ruth, 15 Olcott av., Bernardsville (14)
 East, Isaac C., State Home for Boys, Jamesburg (12)
 Eaton, Arthur T., 201 4th av., Haddon Heights (4)
 Ebner, Paul G., 719 Cooper st., Camden (4)
 Echikson, Jos. I., 845 S. 12th st., Newark (7)
 Eckert, Walter L., 4430 Chestnut st., Phila., Pa. (1)
 Eckhardt, Ralph A., 50 Green Village rd., Madison (14)
 Eddy, Lester R., 40 Bank st., Sussex (19)
 Edelberg, Sidney S., 403 E. High st., Bound Br'k (18)
 Edelen, James J., 280 S. Clinton st., East Orange (7)
 Edelson, Samuel, 1141 Corlies av., Neptune (13)
 Edgar, Jos. A., 71 Congress st., Jersey City (9)
 Edgar, Malcolm S., 129 Summit av., Summit (20)
 Edlkraut, Edward C., 129 Highland av., Passaic (16)
 Edwards, Jas. B., 144 Wood Ridge pl., Leonia (2)
 Edwards, Lena F., 358 Pacific av., Jersey City (9)
 Ehrenfeld, Edward, 185 Lexington av., Passaic (16)
 Ehrenfeld, Irving, 185 Lexington av., Passaic (16)
 Ehrlich, William E., 31 Lincoln Park, Newark (7)
 Eichler, Bernard B., 221 Midland av., Montclair (7)
 Eigen, Louis A., 511 Valley rd., West Orange (7)
 Ein, William B., 31 Lincoln Park, Newark (7)
 Eisenberg, David S., 31 Lincoln Park, Newark (7)
 Ekins, Frank P., 221 Broadway, Paterson (16)
 Elias, Elmer J., 474 Greenwood av., Trenton (11)
 Ellenson, Solomon S., 507 4th av., Asbury Park (13)
 Elliott, Frazier J., 10 N. Second st., Hammonton (1)
 Ellis, Alexander, 513 Broadway, Camden (4)
 Ellis, Arthur J., 282 Broad st., Newark (7)
 Ellmers, Basil J., 230 New Milford av., N'w Milf'd (2)
 Elsasser, Theodore H., 906 Park av., North Bergen (9)
 Ellwell, Alfred M., 407 Cooper st., Camden (4)
 Ely, Lancelot, 128 W. High st., Somerville (18)
 Emerson, Linn, 310 Main st., Orange (7)
 Emmer, S. Wolfe, 31 Lincoln Park, Newark (7)
 Engelhart, Ferdinand K., 701 St'yv's't av., Tr'nt'n (11)
 Englander, Chas., 41 Hillside av., Newark (7)
 English, John T., 681 Stuyvesant av., Irvington (7)
 English, Samuel B., 4th Gardner (10)

- Enright, Jas. G., 25 Kensington av., Jersey C'y (9)
 Epler, Don A., 45 Hillside av., Newark (7)
 Epstein, Rubie, 606 Perry st., Trenton (11)
 Epstein, William M., 31 Lincoln Park, Newark (7)
 Erler, Eugene W., 360 Irving av., S. Orange (7)
 Ernest, Richard B., 240 W. State st., Trenton (11)
 Ervin, Millard B., 572 Prospect st., Maplewood (7)
 Essertier, Edward P., 273 State st., Hackensack (2)
 Esty, Geoffrey W., 629 E. Broad st., Westfield (20)
 Etheridge, Chas. H., 433 Prospect st., E. Orange (7)
 Evans, Charles H., 144 Harrison st., E. Orange (7)
 Evans, David P., 144 Harrison st., E. Orange (7)
 Evans, Edgar E., 12 Ziegler tract, Penns Grove (17)
 Evans, Edgar J., Hinchman av., Denville (14)
 Evans, J. Lawrence, 893 Park av., Woodcliff (9)
 Ewens, Arthur E., 3600 Pacific av., Atlantic City (1)
 Ewing, Harvey M., 31 Trinity pl., Montclair (7)
 Ewing, Leslie H., 10 Broad st., Berlin (4)
 Eynon, Harold K., 579 Haddon av., Collingsw'd (4)

ASSOCIATE MEMBERS

- Ehrlich, Edward, 79 Shanley av., Newark (7)
 Eisenberg, Harry, 473 Washington av., Belleville (7)
 Esposito, Anthony L., 478 Clifton av., Clifton (16)

ACTIVE MEMBERS

- Fabian, Paul L., 520 Princeton av., Trenton (11)
 Facciolo, Francesco, 562 Boulevard, Bayonne (9)
 Fagan, James L., 51 Bayard st., New Brunswick (12)
 Fager, Rudolph O., 53 Park pl., Bloomfield (7)
 Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly (3)
 Failing, Brayton E., 31 Lincoln Park, Newark (7)
 Failmezger, Theodore R., 60 Green av., Madison (14)
 Fairbanks, Warren H., 27 Broadway, Freehold (13)
 Faïson, John B., 45 Glenwood av., Jersey City (9)
 Falcone, Nicholas A., 68 Watchung av., N. Pl'nf'd (18)
 Falkinburg, LeRoy W., Forked River (15)
 Falvello, Nicholas A., 28 Wetmore av., Mor'st'n (14)
 Fanburg, Sol J., 31 Lincoln Park, Newark (7)
 Fanelli, Antonio, 471 Laurie st., Perth Amboy (12)
 Farden, Joseph L., 342 Roseville av., Newark (7)
 Farmer, Walter D., 28 S. Main st., Allentown (11)
 Farr, Irving L., 214 Walnut st., Montclair (7)
 Farr, John C., 75 10th st., Hoboken (9)
 Farr, Walter J., 288 Griggs av., Teaneck (2)
 Farrell, Edgar A. H., 25 Kings Hwy., W., Had'nf'd (4)
 Fattel, Henry C., 5508 Hudson Blvd., N. Bergen (9)
 Faughnan, Rose C., 97 High st., Passaic (7)
 Faulkingham, Ralph J., 61 Liv'gst'n av., N. Bruns. (12)
 Featherston, Daniel F., 506 4th av., Asbury Pk (13)
 Fechner, Julius, 362 Clinton av., Newark (7)
 Federer, John J., 69 Columbia ter., Weehawken (9)
 Fee, Elam K., Main st., Lawrenceville (11)
 Feher, Ladislav A. M., 177 Somers't st., N'w Brns. (12)
 Feigenoff, Israel, 665 Broadway, Paterson (16)
 Fein, Bernard, 585 Elizabeth av., Newark (7)
 Feinberg, Harry D., 384 2nd av., Long Branch (13)
 Feinstein, Louis, 410 Pacific av., Atlantic City (1)
 Feleppa, Edward E., 239 Morris av., Summit (20)
 Fell, Alton S., Municipal Hospital, Trenton (11)
 Feller, Wm., 283 Bergen av., Jersey City (9)
 Fellman, Morris, 118 Jewett av., Jersey City (9)
 Feman, J. George, 141 Main st., Keansburg (13)
 Fendrick, Edward, 17 Watson av., E. Orange (7)
 Feneck, Chas. C., Route 6, Box 330, Phoenix, Ariz. (7)
 Fenichel, Benjamin, 69 Hillside av., Newark (7)
 Fenimore, Edward D., 3663 Hudson Blvd., Jer. C'y (9)
 Fenster, Morton N., 261 Main st., Passaic (16)
 Fenton, Tennant E., 320 Ludlow av., Spring Lk. (13)
 Ferenczi, Louis J., 33 Edwards court, Bayonne (9)
 Ferguson, William E., 22 James st., Newark (7)
 Fernaglich, Harry B., 881 Garrison av., Teaneck (2)
 Fern, Samuel S., 122 Elizabeth av., Newark (7)

Ferrari, Andrew F., 110 Hackensack st., E. R'th'rd (2)
 Ferrary, Paul B., 232 Totowa rd., Totowa Boro (16)
 Ferriss, Ruth B., 51 Maple av., Morristown (14)
 Fessler, A. James, 1544 S. Broad st., Trenton (11)
 Fessman, John W., Clements Br. rd., Runnemede (4)
 Feuer, Joseph A., 654 Elm st., Arlington (7)
 Fewsmith, Joseph L., 120 Second av., Newark (7)
 Ficke, Sylvia A., 884 Summit av., Jersey City (9)
 Field, Frank L., Far Hills (18)
 Fiering, Abraham M., Pmptn.TnPk., M'tain View (16)
 Fifer, William T., 746 Ave. C, Bayonne (9)
 Filkins, Cedric E., 418 White Horse Pk., Audubon (4)
 Fine, Hyman P., 151 Market st., Perth Amboy (12)
 Fine, M. James, 65 Girard pl., Newark (7)
 Fine, Sydney G., N. J. State Hospital, Trenton (11)
 Fineberg, Bernard J., 113 Bentley av., Jersey City (9)
 Fineberg, Jacob C., 50 Glenwood av., Jersey City (9)
 Finegan, Paul J., 200 W. State st., Trenton (11)
 Finesilver, Edward M., 53 Lincoln Park, Newark (7)
 Finger, Frederick A., 938 Ave. C, Bayonne (9)
 Fink, Irving E., 129 Lyons av., Newark (7)
 Finke, Chas. H., 317 York st., Jersey City (9)
 Finke, George W., 237 State st., Hackensack (2)
 Finke, John H. D., 19 Hudson st., Hackensack (2)
 Finkel, Joshua, 368 Clinton av., Newark (7)
 Finkelstein, A. S., 670 Clinton av., Newark (7)
 Finkle, Lester J., 225 Perry st., Trenton (11)
 Finkler, Rita V. S., 35 Leslie st., Newark (7)
 Finn, Frederick A., 2729 Blvd., Jersey City (9)
 Finn, Henry R. W., 84 Lembeck av., Jersey City (9)
 Finnerty, Urban R., 71 Park st., Montclair (7)
 Fiorello, Joseph R., 796 Princeton av., Trenton (11)
 Fischer, Edward J., 20 Ashwood ter., W. Orange (7)
 Fischman, Harold H., 326 Avon av., Newark (7)
 Fish, Clyde M., 7 W. Washington av., Pl's n'tv'le (1)
 Fishbein, Elliot, Valley View Sana., Paterson (16)
 Fisher, James A., 501 Grand av., Asbury Park (13)
 Fisher, Percy C., 145 Franklin av., Ridgewood (2)
 Fisher, Samuel, 808 Madison av., Paterson (16)
 Fishkoff, Alexander H., 132 Market st., P'th Amb'y (12)
 Fisler, Charles F., 140 Maple st., Clayton (8)
 Fitch, Thomas S. P., 916 Park av., Plainfield (20)
 Fithian, George W., 266 High st., Perth Amboy (12)
 Fitzhugh, Wm. F., 190 Euclid av., Ridgefield Pk (2)
 Fitzpatrick, Edw. F., 546 W. Market st., Newark (7)
 FitzPatrick, Leo J., 134 Bergen av., Ridgefield Pk (2)
 Flanagan, John J., 173 Roseville av., Newark (7)
 Fleming, Chas. L., 42 W. Main st., Pennsgrove (17)
 Flichtenfeld, Morris, 283 4th st., Jersey City (9)
 Flicker, David J., 342 Kearny av., Kearny (9)
 Flint, Edgar T., 44 E. Somerset st., Raritan (18)
 Flitcroft, William, 510 River st., Paterson (16)
 Fluck, David A., 548 W. State st., Trenton (11)
 Flynn, Edward A., 161 Washington av., Belleville (7)
 Flynn, Thomas H., 41 High st., Somerville (18)
 Foley, James F., 331 N. Grove st., East Orange (7)
 Fooder, Horace M., 110 Main st., Williamstown (8)
 Forbes, John S., Jr., Cedar st., Basking Ridge (14)
 Ford, Theodore R., 144 Harrison st., E. Orange (7)
 Forer, Robert, 247 Centre st., Trenton (11)
 Forney, Norman N., Sr., 96 N. Main st., Milltown (12)
 Forsyth, Kenneth C., 611 Mt. Prospect av., Newk (7)
 Fort, J. Irving, 306 Roseville av., Newark (7)
 Fort, Wm. B., 147 E. 7th st., Plainfield (20)
 Forte, Frank S., 318 Roseville av., Newark (7)
 Forte, F. Chester, 65 Hudson st., Hackensack (2)
 Fost, Wm. H., 107 Franklin st., Belleville (7)
 Foster, Frank L., 320 Springfield av., Cranford (20)
 Foster, Frank P., 2 Erwin Park, Montclair (7)
 Foster, Herbert W., 2 Erwin Park, Montclair (7)
 Foster, Wm. S., 233 Mt. Prospect av., Newark (7)
 Fowler, Royale H., 744 Broad st., Newark (7)
 Fox, Wm. W., 101 S. Indiana av., Atlantic City (1)
 Frank, Morris, 920 Ave. C, Bayonne (9)

Frank, Myrtle, 227 Philadelphia av., Egg Harbor (1)
 Frank, Nathan, 186 Bowers st., Jersey City (9)
 Franklin, I. Harold, 191 Palisade av., Jersey City (9)
 Franklin, Jos. E., 127 Westfield av., Elizabeth (20)
 Franklin, Lewis J., 618 Selfmaster Pkwy., Union (20)
 Franklin, Sidney I., 163 Washington av., Ft. Lee (2)
 Franzoni, Andrew E., 938 Brunswick av., Trenton (11)
 Fratantuno, Michael J., 152 W. Market st., Newk (7)
 Freedman, Harold H., 63 W. Main st., Freehold (13)
 Freedman, Jacob S., 178 Hamilton av., Passaic (16)
 Freeland, Frank, 281 State st., Hackensack (2)
 Freeman, George C., Prudential Ins. Co., Newark (7)
 Freeman, Richard D., 103 Scotland rd., S. Orange (7)
 Freeman, Ray M., 826 N. Wood av., Linden (20)
 Freile, Wm., 25 Tonnele av., Jersey City (9)
 Freinkel, Jacob, 2 Hillside av., Newark (7)
 French, Frank S., 284 Morris av., Mountain Lks. (14)
 Friedburg, George H., 1108 Anna st., Elizabeth (20)
 Friedland, Arnold J., Woodbine (5)
 Friedman, Abraham I., 280 State st., Hackensack (2)
 Friedman, Harry, 721 S. 16th st., Newark (7)
 Friedman, Hyman, 1096 Sanford av., Irvington (7)
 Friedman, Max, 493 Chambers st., Trenton (11)
 Friedman, Meyer H., 526 N. Clinton av., Trenton (11)
 Friedman, Milton, 31 Lincoln Park, Newark (7)
 Friedmann, Leonard L., 484 Princeton av., Trent'n (11)
 Frieman, Hyman, 744 Ave. C, Bayonne (9)
 Fridrich, Harry E., 4172 Federal st., Camden (4)
 Fritts, Lewis C., 62 E. High st., Somerville (18)
 Froelich, Joseph C., 74 Ingraham pl., Newark (7)
 Frohwein, Ida H., 125 Morristown rd., Elizabeth (20)
 Frost, Inglis F., 181 South st., Morristown (14)
 Frundt, Oscar C., 92 Bartholdi av., Jersey City (9)
 Fuchs, Jacob N., 1267 S. Broad st., Trenton (11)
 Fuhrmann, Barclay S., 10 Main st., Flemington (10)
 Fulper, Theodore B., Hampton (10)
 Furman, Benj. A., 31 Roseville av., Newark (7)
 Furst, Nathan J., 299 Clinton av., Newark (7)

ASSOCIATE MEMBERS

Fader, Ferdinand, 3 S. Grove st., East Orange (7)
 Fazio, Vincent J., 336 Main st., S. Amboy (12)
 Fine, Irvin J., 30 Gordon st., Perth Amboy (12)
 Fischer, David D., 356 Millburn av., Millburn (7)
 Fishbein, Isadore L., 277 Broadway, Paterson (16)
 Fissell, George M., 333 Park av., Newark (7)
 Fleming, Joseph A., 247 Claremont av., Montcl'r (7)
 Fleischmann, Viola G., 341 16th av., Irvington (7)
 Forney, Norman N., Jr., 94 N. Main st., Milltown (12)
 Forte, Daniel L., 545 Central av., Orange (7)
 Fortunato, Samuel J., 345 Walnut st., Newark (7)
 Fraulo, Louis, 310 Crooks av., Clifton (16)
 Fritz, John F., Jr., 1129 Hamilton av., Trenton (11)

ACTIVE MEMBERS

Gadomski, Casimir F., 103 Murray st., Elizabeth (20)
 Gaidner, Thos. M., 319 W. Broad st., Gbbstown (8)
 Galioto, Frank M., 188 Ampere Pkwy., Bloomfield (7)
 Gallardo, Agustin, 61 Lakeside av., Pmptn. Lks. (16)
 Gallaway, George E., 163 W. Milton av., Rahway (20)
 Gallo, James S., 32 Zabriskie st., Haledon (16)
 Gamba, Joseph, 345 Fairmount av., Newark (7)
 Gamon, Robert S., 527 Cooper st., Camden (4)
 Gamsu, George, 2 Stratford pl., Newark (7)
 Ganley, Arthur J., 390 Park av., East Orange (7)
 Gannon, Joseph M., 1137 Park av., Plainfield (20)
 Ganot, F. Irving, 392 Ridge st., Newark (7)
 Gantz, Emma O., 215 N. Grove st., East Orange (7)
 Gardam, Joseph W., 16 Longfellow av., Newark (7)
 Gardner, Kenneth E., 45 Tremont st., Bloomfield (7)
 Garfinkel, Abraham, 30 Broad st., Flemington (10)
 Garibaldi, Louis J., 1016 Hudson st., Hoboken (9)

- Garrett, Harry S., 15 Park av., Park Ridge (2)
 Garrison, Walter S., Main st., Cedarville (6)
 Gauch, William, 177 Elwood av., Newark (7)
 Gauzza, Valentine P., 505 New Br'nsw'k av., Fords (12)
 Geary, Daniel J., 40 Maple av., Morristown (14)
 Geary, Paul, 923 Park av., Plainfield (20)
 Geary, Russell D., Riverside (3)
 Geiger, Harold C., West Milford (16)
 Geissler, Elmer E., 327 Monm'th st., Gloucester (4)
 Gelb, Jerome, 84 W. Alpine st., Newark (7)
 Gelber, Isaac, 2052 Morris av., Union (20)
 Gelber, Louis J., 550 Mt. Prospect av., Newark (7)
 Gennell, Ernest, 298 Parker st., Newark (7)
 George, Melbourne E. W., 744 Broad st., Newark (7)
 Gerendasy, Julius, 956 E. Jersey st., Elizabeth (20)
 Germain, Raymond J., High Bridge (10)
 German, George B., 429 Cooper st., Camden (4)
 Gerne, Timothy A., 972 Summit av., Jersey City (9)
 Gershenfeld, David B., 20 Hillside av., Newark (7)
 Gershman, Joseph G., 99 W. Madison av., Dumont (2)
 Gessner, Gerard R., St. Peter's Hosp., N'w Brnwk. (12)
 Gesswein, Carl A., 35 Church st., Matawan (13)
 Ghee, Euclid P., 115 Claremont av., Jersey City (9)
 Ghee, Peter F., 734 Ocean av., Jersey City (9)
 Giacalone, Vincent, 649 Landis av., Vineland (6)
 Giambra, Sante M., 666 Broadway, Paterson (16)
 Giardina, John S., 341 Walnut st., Newark (7)
 Gibb, Alice S., 339 Union av., Elizabeth (20)
 Gibb, Wm. B., 26 Maple av., Morristown (14)
 Gibbins, Albert L., 119 5th st., Newark (7)
 Gidding, Samuel S., 154 E. Spicer av., Wildwood (5)
 Giffoniello, Arthur A., 200 Fairmount av., Newark (7)
 Gifford, Wm. R., 247 Park av., East Orange (7)
 Giglio, A. S. V., 626 Elizabeth av., Elizabeth (20)
 Gilady, Raphael, 205 Union st., Hackensack (2)
 Gilbertson, Robert L., 500 W. 57th st., N. Y. C'y (14)
 Gille, Hugo, 149 Congress st., Jersey City (9)
 Gillis, Alfred G., 19 W. Maple st., Clayton (8)
 Gillson, Hugh V., 21 Lee pl., Paterson (16)
 Gillson, John T., 170 Broadway, Paterson (16)
 Gilman, Charles M. B., 59 Seeley av., Arlington (7)
 Gilpin, Fletcher, 118 North av. W., Cranford (20)
 Gilson, John A., Jr., 220 8th av., Haddon Heights (4)
 Ginsberg, George, 624 Bloomfield st., Hoboken (9)
 Ginsberg, Leon, Essex Co. Hosp., Cedar Grove (7)
 Ginsburg, Samuel, 227 Paulison av., Passaic (16)
 Girardo, Anthony J., Bates av., W. Berlin (4)
 Gittelman, Morton, 426 Westminster av., Elizabeth (20)
 Gittelsohn, Isador, 896 Kind'r'k'm'k rd., River Edge (2)
 Giuffra, Frank, 99 Valley rd., Montclair (7)
 Glaser, Emanuel, 360 Linden av., Elizabeth (20)
 Glasgow, Thomas M., 120 Passaic av., Passaic (16)
 Glass, Benjamin E., 609 Watchung av., Plainfield (20)
 Glass, Harry L., 923 Park av., Plainfield (20)
 Glass, Oscar, 838 S. 12th st., Newark (7)
 Glass, Wm. H., 144 Harrison st., East Orange (7)
 Glassner, Frank, 308 Chestnut st., Roselle (20)
 Glasston, Hyman M., 628 N. Wood av., Linden (20)
 Glazebrook, Francis H., 37 Ogden pl., Morristown (14)
 Glazer, Edward, 501 Grand av., Asbury Park (13)
 Gleeson, William J., 640 Bergen av., Jersey City (9)
 Glover, Lawrence L., 53 King's Hwy., W., Had'n'f'd (4)
 Gochman, Harry M., 166 Hamilton av., Paterson (16)
 Godfrey, Alan O., 220 Roseville av., Newark (7)
 Godlin, David R., 610 36th st., N. Bergen (9)
 Goeller, Jacob D., 1165 W. Clinton av., Irvington (7)
 Goff, Frank J., 64 Maple av., Red Bank (13)
 Goffman, Emanuel, 316 Claremont av., Montclair (7)
 Goldberg, Benjamin M., 1156 E. State st., Trenton (11)
 Goldberg, David, 7 Bogert pl., Westwood (2)
 Goldberg, Harold H., 814 S. 10th st., Newark (7)
 Goldberg, Harry C., 135 Market st., Perth Amboy (12)
 Goldberg, Louis E., 31 Lincoln Park, Newark (7)
 Goldberg, Samuel A., Presbyterian Hosp., Newark (7)
 Goldberg, Samuel M., 343 Washington av., Bellville (7)
 Golden, Clement H., 347 16th av., Irvington (7)
 Golden, Wm. M., 236 W. Milton av., Rahway (20)
 Goldenberg, Raphael R., 538 E. 27th st., Paterson (16)
 Goldfarb, Abraham, 52 Chestnut st., Rutherford (2)
 Goldfield, Harold H., 225 E. Jersey st., Elizabeth (20)
 Goldgraben, Seymour, 407 Central av., Plainfield (20)
 Golding, Harry N., 180 Carroll st., Paterson (16)
 Goldmacher, Herman B., 113 Elmora av., Elizabeth (20)
 Goldman, Jerome, 148 Chancellor av., Newark (7)
 Goldman, Leo L., 325 Market st., Trenton (11)
 Goldman, Lester M., 896 S. 16th st., Newark (7)
 Goldman, Samuel, 7th & State sts., Camden (4)
 Goldowsky, Ira, 23 Warner av., Jersey City (9)
 Goldsmith, Alfred S., 240 29th st., North Bergen (9)
 Goldstein, Abraham, 404 Madison av., Lakewood (15)
 Goldstein, Henry Z., 31 Lincoln Park, Newark (7)
 Goldstein, Herman H., 318 W. Jersey st., Elizabeth (20)
 Goldstein, Hyman I., 1425 Broadway, Camden (4)
 Goldstein, Joseph D., 2801 Hudson Blvd., Jer. City (9)
 Goldstein, Samuel M., 40 Johnson av., Newark (7)
 Goldstein, Wm. H., 632 Belgrove dr., Kearny (7)
 Goldstone, Karl H., 16 18th st., West New York (9)
 Goncey, Edward J., 538 Jersey av., Elizabeth (20)
 Good, Richard, 949 Park av., Union City (9)
 Goodfellow, Gordon P., 196 Prospect st., E. Orange (7)
 Goodrich, Stewart L., 812 Ave. C, Bayonne (9)
 Gordon, Abel, 616 Main av., Passaic (16)
 Gordon, A. Julius, 351 Roseville av., Newark (7)
 Gordon, Charles D., Mt. Arlington (14)
 Gordon, Clark H., 808 E. State st., Trenton (11)
 Gordon, Joseph, Bergen Pines, Oradell (2)
 Gordon, J. Berkeley, N. J. State Hosp., Marlboro (13)
 Gordon, Milton H., 12 N. 27th st., Camden (4)
 Gordon, Osher, 119 Lexington av., Passaic (16)
 Gordon, Samuel, 515 Broadway, Paterson (16)
 Gorenberg, Harold, 54 Duncan av., Jersey City (9)
 Gormley, Cyrus M., 6 Roberts st., Butler (16)
 Gorson, Samuel F., 2005 Pacific av., Atlantic City (1)
 Gould, J. Howard, 263 Franklin av., Ridgewood (16)
 Graddick, Lester W., 22 Sussex av., Morristown (14)
 Grady, Wm. F., 42 N. Fullerton av., Montclair (7)
 Graham, Archibald F., 42 Park av., Paterson (16)
 Graham, Ernest E., 4273 S. Broad st., Yardville (11)
 Graham, Richard B., 575 Belgrove dr., Arlington (7)
 Graham, Theodore K., 279 Park av., Paterson (16)
 Gramsch, A. Louis, Bergen Pines, Oradell (2)
 Granelli, Humbert A., 213 Garden st., Hoboken (9)
 Grant, Wm. E., 1939 Morris av., Union (20)
 Grant, Wm. F., 309 Roseville av., Newark (7)
 Graves, Chas. C., Jr., State Hosp., Marlboro (13)
 Gray, Chas. M., 6th & Grape sts., Vineland (6)
 Gray, John W., 142 Clinton av., Newark (7)
 Gray, W. Burritt, 121 Somerset st., N. Plainfield (18)
 Green, David W., 69 Market st., Salem (17)
 Green, Thomas J., New Egypt (15)
 Greenberg, Geo. A., 195 W. High st., Somerville (18)
 Greenberg, Philip, 1902 Hudson Blvd., Jersey City (9)
 Greenberg, Samuel, 46 Johnson av., Newark (7)
 Greene, Albert D., 195 Pal'sade av., Union City (9)
 Greene, Harry, 3285 Hudson Blvd., Jersey City (9)
 Greenfield, Arthur W., 50 Anderson st., Hackensack (2)
 Greenfield, Bernard H., 691 Clinton av., Newark (7)
 Greenfield, Leonard S., 691 Clinton av., Newark (7)
 Greenfield, Wm. J., 50 Anderson st., Hackensack (2)
 Greengrass, Jacob J., 146 Broadway, Paterson (16)
 Greenwald, Theo. L., 44 Maple av., Morristown (7)
 Greer, Melvin A., 190 Washington st., Bloomfield (7)
 Gregorius, Ralph F., 120 Irvington av., S. Orange (7)
 Gregory, Marie F., 50 Green Village rd., Madison (14)
 Gregory, Mildred G., 64 N. 9th st., Newark (7)
 Gregory, Roy A., 161 Crescent av., Plainfield (20)
 Greifinger, Marcus H., 200 Ferry st., Newark (7)
 Grenhart, Geo. W., 430 Haddon av., Camden (4)

Grewal, Joseph S., 196 Broadway, Bayonne (9)
Grieco, Emil H., 196 Broadway, Bayonne (9)
Grier, Robt. M., 50 E. Wash'gt'n av., Pl'santville (1)
Griesemer, Z. Lawrence, 1143 E. Jersey st., Eliz.(20)
Grieve, James, 88 Market st., Perth Amboy (12)
Griffey, Wm. C., 132 Haddon av., Westmont (4)
Griffin, Guy B., 197 S. Centre st., Orange (7)
Griffith, Roy, 909 Broad st., Newark (7)
Griscom, I. Norwood, 204 Church st., Boonton (14)
Griswold, Merton L., Jr., 949 Park av., Plainfield(20)
Groeschel, August H., 31 Bank st., Sussex (19)
Groff, Parker A., 159 Washington av., Little Ferry(2)
Gross, Isidore, 60 Lakeside av., Verona (7)
Gross, Max, Glen Gardner (10)
Grossblatt, Philip, 70 Baldwin av., Newark (7)
Grossman, Rubin, 416 Boulevard, Bayonne (9)
Gruhler, Jean A., 5407 Atlantic av., Ventnor (1)
Grunt, Louis, 404 Bergen st., Newark (7)
Guarraia, Jos., 285 Van Winkle av., Hawthorne (16)
Guertin, Diomedee, Skillman (18)
Guglielmelli, Angelo D., 449 Hamilton av., Trent'n(11)
Guidi, Guido M., 212 Christine st., Elizabeth (20)
Guidotti, Frank P., 1022 Greenwood av., Trenton(11)
Guilliam, Wm. H., 505 Fourth av., Asbury Park(13)
Guion, Edward, Atlantic Co. Hosp., Northfield (1)
Gulick, James B., 144 S. Harrison st., E. Orange (7)
Gullord, Edward G., 205 Alexander av., Up.M'tcl'r(7)
Gurshman, Sol., 280 Amboy av., Metuchen (12)
Guthrie, Wilson G., 300 Summer av., Newark (7)
Gutmann, Erwin K., 229 Bowers st., Jersey City (9)
Gutowski, Jos. M., 433 Brace av., Perth Amboy (12)
Gutowski, Walter T., 104 Grove ter., Irvington (7)

ASSOCIATE MEMBERS

Gadek, Wm. V., 495 State st., Perth Amboy (12)
Gaylor, Earl L., Jr., 56 Church st., Montclair (7)
Gelman, Sidney, 345 Broadway, Paterson (16)
Gerebin, Arpad, 511 Rahway av., Woodbridge (12)
Gibson, Augustus, 635 Valley rd., Up. Montclair (7)
Goldman, Solomon, 43 Paterson st., New Bruns.(12)
Graeter, F. Albert, 265 Gregory av., Passaic (16)
Greenwood, Wm. R., Rutgers Univ., New Bruns.(12)
Greifinger, Wm., 619 Stuyvesant av., Irvington (7)
Grueninger, Edward F., 24 Columbia av., Grantw'd(2)

ACTIVE MEMBERS

Hackett, Edward J., 597 Westfield av., Westfield(20)
Hackett, Leon W., 173 Belvidere av., Washington(21)
Hadley, C. Frazer, 210 W. Maple av., Merch'tville(4)
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont(4)
Hadley, Elinor E., 5 Mountain av., Maplewood (7)
Hagen, Orville R., 266 Van Houten st., Paterson(16)
Haggerty, D. Leo, 227 N. Warren st., Trenton (11)
Hagman, Frank E., 131 Ridge rd., N. Arlington (7)
Hagney, Frederick W., 669 Elizabeth av., Newark(7)
Hahn, Katherine B., 372 Thornden st., S. Orange(7)
Hahn, William H., 15 Lombardy st., Newark (7)
Haight, Harry W., 118 Raritan av., New Bruns'w'k(12)
Haines, Edgar J., Medford (3)
Haines, Emerson S., 500 8th av., Asbury Park (13)
Haines, Evelyn M., 1022 Greenw'd av., Trenton (11)
Haines, Mabel C. S., 600 White Horse Pk., Audubon(4)
Haines, Wm. H., 600 White Horse Pike, Audubon(4)
Haines, Willits P., 601 9th st., Ocean City (5)
Halbach, Robt. McC., 802 Main st., Toms River (15)
Haldeman, Robert E., Mt. Holly (3)
Hale, Henry E., Jr., Battlefield Farm, Princeton (11)
Haley, Paul W., 781 Sanford av., Newark (7)
Hall, Perry O., 254 Union st., Jersey City (9)
Hall, Wayne W., 266 Van Houten st., Paterson (16)
Hall, Winthrop H., 400 Elm st., Westfield (20)
Hallett, Frederick S., 200 Passaic st., Hackensack(2)
Halligan, Earl J., 254 Montgomery st., Jer.City(9)

Hallinger, Earl S., 517 Cooper st., Camden (4)
Hallock, Wilton J., 650 Springfield av., Summit (20)
Halperin, David, 590 Bergen av., Jersey City (9)
Halpern, Herman, 143 Engle st., Englewood (2)
Halpern, Melvin M., 493 Central av., Newark (7)
Halpern, Samuel, 504 Pacific av., Atlantic City (1)
Halpern, Sophia L., 271 Palisade av., Union City (9)
Halprin, Harry, 8 Washburn pl., Caldwell (7)
Halsey, Levi W., 61 Church st., Montclair (7)
Hamblin, Donald O., Calco Chem. Co., Bound Br'k(18)
Hambright, Arthur M., Wyckoff av., Ramsey (16)
Hamilton, Lloyd A., 46 York st., Lambertville (10)
Hamilton, Robert G., 92 Main st., Orange (7)
Hammell, Frank M., 137 S. Main st., Allentown (11)
Hammett, Lee J., 760 N. 27th st., Camden (4)
Hampton, George R., Greystone Park (14)
Hanan, James T., 11 The Crescent, Montclair (7)
Hancock, Michael Q., 705 D st., Belmar (13)
Haney, John J., 850 Hamilton av., Trenton (11)
Hansen, Harry, 831 Madison av., Plainfield (20)
Hanson, Alfred S., 533 Monmouth st., Gloucester(4)
Hanson, Carl G., 38 Springfield av., Cranford (20)
Hanson, Edward K., 684 Amboy av., Fords (12)
Hantman, Harold, 196 Roseville av., Newark (7)
Harden, Albert S., 510 W. Market st., Newark (7)
Harden, Albert S., Jr., 536 Ridgew'd rd., Maplew'd(7)
Hardy, John W., 53 Main st., Farmingdale (13)
Harhen, George E., 22 Brookside av., Caldwell (7)
Harley, Halvor L., 101 S. Indiana av., Atl. City(1)
Harman, James R., 824 W. State st., Trenton (11)
Harman, William J., 740 W. State st., Trenton (11)
Harreys, Charles W., 714 Broadway, Paterson (16)
Harrington, J. Henry, 126 E. Main st., Rockaway(14)
Harris, Wm. O., 812 Arctic av., Atlantic City (1)
Harris, William G., Main st., Mullica Hill (8)
Harrison, Joseph B., 302 E. Broad st., Westfield (20)
Harter, Louis F., 174 Bowers st., Jersey City (9)
Hartman, Luther M., 8 E. Main st., Maple Shade(3)
Hartwell, H. Ameroy, 777 Blvd., E., Weehawken (9)
Harvey, John W., 818 Ave. C, Bayonne (9)
Harvey, Robt. K., 753 Kearny av., Arlington (7)
Harvey, Thomas W., Jr., 59 Main st., Orange (7)
Haseltine, Sherwin L., 125 Broad st., Elizabeth (20)
Hasking, Arthur P., 318 Montgomery st., Jer.City(9)
Hasney, Frederick A., 292 Main st., W. Orange (7)
Hatch, Harold S., Shonghum Mt. Sana., Morrist'n(14)
Hatcher, George A., Essex Co. Hosp., Cedar Gr. (7)
Hatem, Elias J., 1046 Main st., Paterson (16)
Hauber, Eugene A., 6 Quaid st., Sayreville (12)
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington(7)
Hauck, Wm. H., 644 Stuyvesant av., Irvington(7)
Hausman, Samuel W., 50 W. Front st., Red B'k(13)
Haussling, Francis R., 661 High st., Newark (7)
Haven, Samuel C., 14 Elm st., Morristown (14)
Hawes, Vernon L., 63 Church st., Ramsey (2)
Hawkes, E. Zeh, 84 Washington st., Newark (7)
Hawkes, Stuart Z., 84 Washington st., Newark (7)
Hayes, Gerald W., 86 Hawthorne av., E. Orange (7)
Hays, Roy G., 567 Haddon av., Collingswood (4)
Haywood, Henry, 49 Paterson st., New Bruns'w'k(12)
Heatley, Wm., 23 Monmouth st., Red Bank (13)
Hegeman, Runkle F., 161 W. High st., Som'rville(18)
Heil, Alva A., Milford (10)
Heilbrunn, Julius, 135 Bel'mont av., Jersey City (9)
Heineken, Theodore S., 17 Park pl., Bloomfield (7)
Heinig, Frank G., 124 Cornelia st., Boonton (14)
Hekimian, Jacob H., 468 Palisade av., Weehaw'n(9)
Helff, Joseph R., 1367 Teaneck rd., W. Englew'd (2)
Heller, Abraham R., 10 Kearny av., Kearny (7)
Heller, George, 100 E. Palisade av., Englewood (2)
Heller, Nathan B., 31 Lincoln Park, Newark (7)
Heminway, Norman, Somerville (18)
Hemphill, Everett H., 232 Kings Hwy., E., H'd'nf'd(4)
Henderson, Kenneth P., 121 S. Illinois av., Atl.C'y(1)

- Henle, Caryl-Belle, 671 Springfield av., Newark (7)
 Hennig, Paul F., 688 Stuyvesant av., Irvington (7)
 Henriksen, J. Bruce, 422 River av., P't Pl'sant (15)
 Henry, Frank C., Jr., 214 Smith st., PerthAmboy(12)
 Herbener, Eugene G., 423 Third st., Lakewood (15)
 Hermann, John H., 197 S. Centre st., Orange (7)
 Herndon, Lewis S., 144 S. Harrison st., E.Orange(7)
 Herold, Harvey T., 850 S. 13th st., Newark (7)
 Herradora-Ubeda, Juan R., 2787 Blvd., Jersey C'y(9)
 Herrington, Lee R., 605 E. Broad st., Westfield (20)
 Herrman, William G., 501 Grand av., AsburyPk(13)
 Hersh, David H., 658 Springfield av., Newark (7)
 Hersohn, Wm. W., 116 S. Illinois av., Atl. City (1)
 Hess, George A., River rd., Titusville (11)
 Hess, Louis E., 19 E. Bolton av., Absecon (1)
 Hessert, Edmund C., 700 Haddon av., Collingswd(4)
 Hewson, George F., 21 Roseville av., Newark (7)
 Hexamer, Fred, 50 Lyons av., Newark (7)
 Heyman, Arthur, 79 Baldwin av., Newark (7)
 Hiden, Joseph C., 199 Nassau st., Princeton (11)
 Higgins, Gerald L., 94 Lembeck av., Jer. City (9)
 Higgins, John T., 145 Highland av., Jersey City (9)
 Higgins, Thos. A., 2616 Hudson Blvd., Jersey C'y(9)
 Hiler, Stuart A., 62 Rockaway av., Rockaway (14)
 Hilker, George F., 258 Maple st., Perth Amboy (12)
 Hill, Clarence T., 43 E. Hazelwood av., Rahway (20)
 Hill, John A., 511 Cedar av., Allenhurst (13)
 Hill, Robert H., 339 Parker st., Newark (7)
 Hill, William F., 104 Grand st., Jersey City (9)
 Hillegass, Eugene Z., Main st., Mantua (8)
 Hillel, Joseph, 1394 Park av., Hudson Heights (9)
 Hilliard, William T., 105 Market st., Salem (17)
 Hillman, Frederick C., 64 Hamilton st., Paterson(16)
 Hinton, Samuel H., 123 Main st., Sayreville (12)
 Hipple, Percy L., 230 Walnut st., Roselle (20)
 Hird, Emerson F., 118 E. Maple av., Bound Br'k(18)
 Hirsch, Samuel, 118 Lexington av., Passaic (16)
 Hirschfeld, Bernard A., 438 Hamilton av., Trenton(11)
 Hirst, E. Reed, 634 Federal st., Camden (4)
 Hitzemann, Louis A., 30 E. Passaic st., Maywood(2)
 Hnat, Frederick, 624 Newark av., Elizabeth (20)
 Hobart, Richard T., 454 Park st., UpperMontcl'r(7)
 Hodas, Sidney M., N. J. State Hosp., Marlboro (13)
 Hoffman, Charles A., 302 E. 7th st., Plainfield (20)
 Hoffman, Florentine M., 91 Bayard st., N'wBrns.(12)
 Hoffman, Harry S., 3302 Pacific av., Atlantic City(1)
 Hogan, James J., New Egypt (15)
 Hogan, Marshall D., 311 W. Main st., Boonton (14)
 Hoheb, Albert S., 5 Lincoln av., Rutherford (2)
 Holland, George A., 364 Clinton av., Newark (7)
 Holland, John A., 1219 W. State st., Trenton (11)
 Holland, Reuben J., 1026 Chandler av., Linden (20)
 Holler, Henry G., 234 Montclair av., Newark (7)
 Hollingsworth, Herman H., 86 First st., Clifton (16)
 Hollingshead, Lyman B., Pemberton (3)
 Hollinshead, Beulah S., 600 Benson st., Camden (4)
 Hollinshead, Ralph K., 351 Broadway, Westville (8)
 Hollywood, Jas. L., 1818 Hudson Blvd., Jer. City(9)
 Holman, Francis W., 123 Broad st., Keyport (13)
 Holmes, Grace A., 1077 E. Jersey st., Elizabeth (20)
 Holmes, George J., 17 Elizabeth av., Newark (7)
 Holmes, H. David, 1813 Arctic av., Atlantic City (1)
 Holmes, Thos. J. E., 151 Fair st., Paterson (16)
 Holoman, M. Browne, 1 N.Haverford av., Margate(1)
 Holster, Stephen G., 951 Madison av., Paterson (16)
 Holt, Edward Z., 4100 Atlantic av., Atlantic City(1)
 Holt, Evelyn, 261 Springfield av., Summit (20)
 Holt, Herman H., 256 Graham av., Paterson (16)
 Holters, Otto R., 1002 Emory st., Asbury Park (13)
 Hoops, Harold J., 2203 Boulevard, Jersey City (9)
 Hooton, Thomas C., 56 Church st., Montclair (7)
 Hoover, Alden R., 721 N. Broad st., Elizabeth (20)
 Horhovitz, George I., 324 S. Broad st., Trenton (11)
 Horn, Harry, 622 Stuyvesant av., Irvington (7)
 Horn, Max, 94 Lyons av., Newark (7)
 Hornberger, J. Howard, 5 Fifth av., Roebling (3)
 Horner-Rodger, Clara L., 721 Cooper st., Camden(4)
 Hornstine, Harry H., 4015 Pacific av., Wildwood (5)
 Horoschak, Anne, 974 Park av., Plainfield (20)
 Horowitz, Herman J., 872 Broad av., Ridgefield (2)
 Horre, George W. H., 203 W. Jersey st., Elizab'h(20)
 Horsford, Frederick C., 305 Broadway, Newark (7)
 Hosp, Paul H., 842 S. 12th st., Newark (7)
 Houck, Wm. J., 207 Mt. Prospect av., Newark (7)
 Howard, Jas. W., 87 Midland av., Montclair (7)
 Howard, J. Edgar, 67 King's Hwy., W., Had'nf'd(4)
 Howeth, John L., 14 Duncan av., Jersey City (9)
 Howley, Bartholomew M., 419 George st., N'wBrns.(12)
 Hubbard, Fayette E., 65 Church st., Montclair (7)
 Hubbard, Harry V., 121 E. 7th st., Plainfield (20)
 Hubbard, Robert Y., 942 Sanford av., Irvington (7)
 Huber, William H., 15 Salem st., Newark (7)
 Huberman, John, 853 S. 12th st., Newark (7)
 Hubert, Antonio O., 131 E. Main st., Rockaway (14)
 Hudson, Howard S., 34 E. Main st., MaysLanding(1)
 Hudson, Woodburn J., 123 W. W'h'gt'n av., P'tntv'le(1)
 Huff, Edmund N., 1635 Bedford rd., SanMarinoCal.(2)
 Hughes, Frank R., Columbia av. & Oc'n st., CapeM'y(5)
 Hughes, Frederic J., 706 Park av., Plainfield (20)
 Hughes, John V., 150 Prospect st., Passaic (16)
 Hughes, Joseph F., 116 N. Broad st., Woodbury (8)
 Hughes, Lee W., 965 Broad st., Newark (7)
 Hughes, Sam'l B., Pine & Pacific avs., Wildwood(5)
 Hulett, Albert G., 20 Hawthorne av., E. Orange (7)
 Hull, Donald B., 7 W. Ridgewood av., Ridgewood(2)
 Hummell, Ernest G., 414 Cooper st., Camden (4)
 Hummel, Lee C., 109 W. Broadway, Salem (17)
 Hummel, Merwin L., 135 N. Centre st., Merch'ntv'le(4)
 Humphries, Robert E., 637 Central av., E. Orange(7)
 Hunt, Melvin M., 140 Jackson st., South River (12)
 Hunt, Thomas F., 528 Monroe av., Elizabeth (20)
 Hunter, Edward R., 321 Union av., Delanco (3)
 Hunter, Floyd D., 3620 Not'gh'm way, Hamilt'nSq.(11)
 Hunter, Harold H., 114 W. Broad st., Paulsboro (8)
 Huoni, John S., Sun Oil Co., Linden (20)
 Hurff, J. Wallace, 86 Washington st., Newark (7)
 Husserl, Siegfried, 777 Clinton av., Newark (7)
 Husted, Gerald W., 306 8th av., Haddon Heights (4)
 Husted, Samuel H., Neshanic Station (18)
 Hutcheson, Charles R., 517 Cooper st., Camden (4)
 Hutchinson, A. Dunbar, 913 W. State st., Trenton(11)
 Hutchinson, Geo. F., 55 Mercer st., Hamilton Sq.(11)
 Hutner, Cyril I., 134 Grove st., Woodbridge (12)
 Hutton, Frederick T., 1012 Park av., Plainfield (20)
 Hyman, Charles, 2619 Pacific av., Atlantic City (1)
 Hymowitz, Ben, 519 Belmont av., Newark (7)

ASSOCIATE MEMBERS

- Hafetz, M. Morris, 114 Centre st., Trenton (11)
 Harrop, George A., 33 Cleveland lane, Princeton(11)
 Hensle, Otto S., 428 First st., Carlstadt (2)
 Hesseltine, Clair E., 269 Borden't'n av., S. Amboy(12)
 Hoffman, Charles W., 216 Henry st., S. Amboy (12)
 Holtz, Harry M., 56 Johnson av., Newark (7)
 Howell, Thomas W., 47 Central av., Newark (7)

ACTIVE MEMBERS

- Iams, Samuel H., 245 Library pl., Princeton (11)
 Ianacone, John A., 310 Fifth av., Paterson (16)
 Ill, Carl H., 188 Clinton av., Newark (7)
 Ill, Charles L., 188 Clinton av., Newark (7)
 Ill, Edgar A., 1004 Broad st., Newark (7)
 Ill, Edmund W., 188 Clinton av., Newark (7)
 Ill, Edward J., 1004 Broad st., Newark (7)
 Ill, Herbert M., 188 Clinton av., Newark (7)
 Imbleau, Joseph E. L., 2106 Morris av., Union (20)

Imhoff, John G., 55 Lincoln st., Jersey City (9)
Imhoff, Robert E., 29 E. Main st., Moorestown (3)
Infield, Gerald L., 1401 Shore rd., Northfield (1)
Ingling, Harry W., 51 W. Main st., Freehold (13)
Introcaso, Dominick A., 45 Crescent av., Jer. City(9)
Iraggi, James V., 79 Broadway, Passaic (16)
Ireland, Allen G., 28 W. State st., Trenton (11)
Ironsides, Paul, 571 Benson st., Camden (4)
Irvin, John S., 1910 Pacific av., Atlantic City (1)
Irving, Albert S., 318 Howard av., Fairlawn (16)
Irwin, James R., 330 Washington av., Belleville (7)
Irwin, John H., 51 Tenaflly rd., Englewood (2)
Israeloff, Howard H., 1044 Clinton av., Irvington (7)
Ives, Edwin L., 24 Stevens av., Little Falls (16)
Ivins, William C., 214 E. Hanover st., Trenton (11)
Ivory, Harry S., cor. Richm'd & F'r'm'n avs., Pt. Plst. (15)
Izenberg, David, 104 Carroll st., Paterson (16)

ACTIVE MEMBERS

Jablonski, John J., 100 Main st., Sayreville (12)
Jack, H. Wesley, 517 Cooper st., Camden (4)
Jacks, Oscar, 476 Mercer st., Jersey City (9)
Jackson, Albert F., 225 Hillside av., Nutley (7)
Jackson, Charles H., 1250 Park Blvd., Camden (4)
Jackson, Elmer C., 98 Washington st., E. Orange (7)
Jacobs, Alan L., 2130 Morris av., Union (20)
Jacobs, William, 1013 Clinton av., Irvington (7)
Jacobson, John J., 1616 Pacific av., Atlantic City (1)
Jacobson, Murray B., 241 State st., Perth Amboy (12)
Jaffe, Benjamin, 566 Bergen av., Jersey City (9)
Jaffe, Herman M., 2600 Blvd., Jersey City (9)
Jaffin, Abraham E., 41 Emory st., Jersey City (9)
Jahn, Albert G., 657 Main av., Passaic (16)
James, Bart M., 31 Lincoln Park, Newark (7)
James, William H., Main st., Pennsville (17)
James, William L., 31 Lincoln Park, Newark (7)
Jamison, Wm. F., 501 Grand av., Asbury Park (13)
Jani, Frank F., 297 Lexington av., Passaic (16)
Janifer, Clarence S., 208 Parker st., Newark (7)
Jaques, J. Eugenia, 74 Waverly st., Jersey City (9)
Jarmulowsky, Harry, 181 E. 33rd st., Paterson (16)
Jarrett, Harry, 923 Broadway, Camden (4)
Jaso, James V. Di, 710 Varsity rd., S. Orange (7)
Jaspan, Samuel C., 820 Division st., Trenton (11)
Jedel, Meyer, 125 Fourth st., Newark (7)
Jehl, Joseph R., 305 Clifton av., Clifton (16)
Jenkins, Alvah R., 40 Armory st., Englewood (2)
Jenkins, Arthur M., 701 Harrison st., French'n (10)
Jennings, Edw. C., R.F.D. No. 1, Cape May C'ths. (5)
Jennings, Robert E., 143 Park st., East Orange (7)
Jentz, John H., 63 Sherman pl., Jersey City (9)
Jessurun, Samuel H., 613 High st., Newark (7)
Jirouch, Edwin A., 18 Ziegler tract, Pennsgrove (17)
Joelson, Morris S., 577 Broadway, Paterson (16)
Joffe, Philip M., 556 E. 28th st., Paterson (16)
Joffe, Sidney H., 556 E. 28th st., Paterson (16)
Johnsen, Sigurd W., 49 Passaic av., Passaic (16)
Johnson, George F., Branchville (19)
Johnson, G. Leonard, 390 Booth av., Englewood (2)
Johnson, George L., 27 High st., Morristown (14)
Johnson, Harold F., 734 Park av., Plainfield (20)
Johnson, V. Earl, 101 S. Indiana av., Atlantic C'y (1)
Johnston, Sidney F., 365 Rochelle av., Rochelle Pk (2)
Jonas, August, 218 E. Pine av., Wildwood (5)
Jones, Clement M., 438 Boulevard, Bayonne (9)
Jones, Edward C., 183 Grove st., Montclair (7)
Jones, Granville L., N. J. State Hosp., Marlboro (13)
Jones, Herbert E., 612 Emerson av., Elizabeth (20)
Jones, John C., 805 Princeton av., Camden (4)
Jones, John M., Valley rd., R.F.D., Oakland (9)
Jones, Lewis H., 139 E. Grant av., Roselle Park (20)
Jones, Wm. R., 33 S. Fullerton av., Montclair (7)
Jonitz, Robert, 153 S. Grove st., East Orange (7)

Jordan, Alexander D., 238 E. Main st., Manasquan (13)
Jordan, Joseph C., 238 E. Main st., Manasquan (13)
Jordan, Walter L., 146 Engle st., Englewood (2)
Joseph, Benjamin M., 2771 Hudson Blvd., Jer. C'y (9)
Joseph, Morris, 271 Lexington av., Passaic (16)
Joyce, Leo H., 259 Madison st., Passaic (16)
Judd, Wilbur M., N. J. State Hosp., Greyston Pk (14)
Judge, John F., 33 Hazelwood av., Newark (7)
Jukofsky, Isidore D., 32 Union pl., Ridgefield Pk (2)
Just, Francis, 564 High st., Newark (7)
Justin, Arthur W., 41 Fulton st., Weehawken (9)

ASSOCIATE MEMBERS

James, J. Thomas, 57 Wiggins st., Princeton (11)
Janoff, Henry, 626 Perry st., Trenton (11)
Johnson, John F., 203 Abernethy dr., Trenton (11)
Jones, Elwood K., 82 S. Harrison st., East Orange (7)

ACTIVE MEMBERS

Kachdorian, Vartan, 930 Brunswick av., Trenton (11)
Kaderabek, Erwin J., 144 S. Harrison st., E. Orange (7)
Kahn, Leo, 32 States av., Atlantic City (1)
Kahrs, Grace M., 140 Roseville av., Newark (7)
Kaighn, Charles B., 905 Pacific av., Atlantic City (1)
Kain, Thomas M., 403 Cooper st., Camden (4)
Kakascik, Emil J., 206 Palisade av., Garfield (2)
Kalb, Samuel W., 416 Clinton pl., Newark (7)
Kalter, George E., 640 Prospect st., Maplewood (7)
Kaminsky, Aaron L., 13 Poe av., Newark (7)
Kane, Charles J., 984 E. 23rd st., Paterson (16)
Kanes, Edmund S., 51 W. River rd., Rumson (13)
Kaplan, Benjamin E., 695 Clinton av., Newark (7)
Kaplan, Herman B., 324 44th st., Union City (9)
Kaplan, Samuel D., 149 Bailey av., Hillside (20)
Kaplan, S. Bernard, 846 S. 12th st., Newark (7)
Kapp, Carl G., 440 Westminster av., Elizabeth (20)
Karshmer, Ernest E., 927 S. Wood av., Linden (20)
Karshmer, Nathan, 92 Carroll pl., New Brunswick (12)
Kassow, Philip B., North Blvd., Alpha (21)
Kastler, Franz, 54 Ames av., Rutherford (2)
Katz, Jacob D., 115 Belmont av., Jersey City (9)
Katzin, Eugene M., 50 Baldwin av., Newark (7)
Kauffmann, Louis J., 232 N. 2nd st., Millville (6)
Kaufman, Jerome G., 299 Clinton av., Newark (7)
Kaufman, Michael J., 103 Lyons av., Newark (7)
Kavanaugh, Daniel E., 217 Broadway, Newark (7)
Kay, Clarence R., Peapack (18)
Kazmann, Harold A., 406 Broadway, Long Branch (13)
Kearney, Edw. P. J., 83 S. Fullerton av., Mt. Clr. (7)
Kearney, John V., 331 34th st., N. Bergen (9)
Keating, Chas. A., 177 Ellison st., Paterson (16)
Keegan, Thomas D., 8 Gifford av., Jersey City (9)
Keeney, Caldwell B., 137 Summit av., Summit (20)
Keeney, James C., 1201 Park av., Hoboken (9)
Keim, William F., 25 Roseville av., Newark (7)
Keir, Floyd E., 308 Engle st., Englewood (2)
Keller, Franklin J., 297 Diamond Br. av., Hawthorne (16)
Keller, Michael L., 268 Park av., Paterson (16)
Keller, Paul, 15 Washington st., Newark (7)
Keller, Sidney C., 31 Lincoln Park, Newark (7)
Kelley, Chas. B., 921 Bergen av., Jersey City (9)
Kelly, Bernard S., 1954 Boulevard, Jersey City (9)
Kelly, Harry R. J., 311A Brown st., Union City (9)
Kemeny, Imre, 48 Pulaski av., Carteret (12)
Kemper, Harry T., 224 Monmouth rd., Elizabeth (20)
Kennedy, A. Andrew, 6 Eagle av., Paterson (16)
Kennedy, Eugene T., 413 W'n'que av., Pmptn. Lks. (16)
Kennedy, Paul A., 147 Tenaflly rd., Englewood (2)
Kenney, John A., 134 W. Kinney st., Newark (7)
Keppler, Chas., Jr., 723 Allwood rd., Clifton (16)
Kerdasha, George S., 131 31st st., N. Bergen (9)
Kern, E. Clarence, 45 Park st., Montclair (7)

Kessell, John S., 643 Central av., East Orange (7)
 Kessler, Edward I., N. J. State Hosp., Grystine Pk (14)
 Kessler, Henry B., 666 Clinton av., Newark (7)
 Kessler, Henry H., 53 Lincoln Park, Newark (7)
 Keyser, David, 1518 Baird av., Camden (4)
 Kiely, Eugene M., 800 Hudson st., Hoboken (9)
 Kilduffe, Robt. A., Atlantic City Hosp., Atl. City (1)
 Kiley, John E., 94 Park st., Montclair (7)
 Kim, Gay B., St. Joseph's Hosp., Paterson (16)
 Kimmel, Chas., 9 Eaton pl., Bloomfield (7)
 Kimmel, Meyer L., 142 Manhattan av., Jersey C'y (9)
 Kinch, Frederick A., 267 E. Broad st., Westfield (20)
 King, Alden P., 44 W. Blackwell st., Dover (14)
 King, Chester A., 412 Kinderkam'k rd., Oradell (2)
 Kinkead, Hilda, 51 Highland av., Madison (14)
 Kinney, Albert G., 917 Haddon av., Collingswd (4)
 Kinney, Burton O., 41 Lincoln av., Little Falls (16)
 Kinney, Selden T., 250 Main st., South Amboy (12)
 Kirkby, Cyril S., 128 Broad st., Bloomfield (7)
 Kirkman, Leroy G., 176 Roseville av., Newark (7)
 Kirkwood, Allan S., 53 Union st., Montclair (7)
 Kirschner, Martin I., Vernon (19)
 Kissinger, Donald J., 120 E. Madison av., Dumont (2)
 Klaus, Henry, 435 Palisade av., Union City (9)
 Kleiber, Estelle E., 139 New st., New Brunswick (12)
 Klein, Alexander, 328 High st., Perth Amboy (12)
 Klein, Andrew J. V., 209 Littleton av., Newark (7)
 Klein, Edward C., Jr., 209 Littleton av., Newark (7)
 Klein, William, 85 Bayard st., New Brunswick (12)
 Kleinberger, Harry H., 59 Main st., Millburn (7)
 Kleiner, Samuel, 162 Hamilton av., Paterson (16)
 Klempner, Paul, 414 Market st., Trenton (11)
 Klenk, Joseph P., 328 Belleville av., Bloomfield (7)
 Kler, Joseph H., 77 Livingston av., New Brunswick (12)
 Kline, George L., 310 Mt. Prospect av., Newark (7)
 Kline, Herman, 2643 Pacific av., Atlantic City (1)
 Kline, Oram R., 414 Cooper st., Camden (4)
 Klompus, Irving, 403 High st., Bound Brook (18)
 Knapp, Rich'd E., 25 Hudson st., Hackensack (2)
 Knauer, George, 930 Elizabeth av., Elizabeth (20)
 Knepper, Orcena F., 149 Crescent av., Plainfield (20)
 Knight, Augustus S., Far Hills (18)
 Knight, I. Warner, 13½ S. Broadway, Pitman (8)
 *Knight, Wm. T., 515 Oradell av., Oradell (2)
 Knopf, Edward, 343 Fairmount av., Jersey City (9)
 Knowles, George M., 241 Main st., Hackensack (2)
 Knowles, James S., 318 N. 2nd st., Millville (6)
 Knox, Harriet L., 390 Union st., Hackensack (2)
 Knox, Howard A., New Hampton (10)
 Kobes, John J., 138 Kearny av., Kearny (7)
 Koelsch, Fred'k J., 14 Kirkpatrick st., N'w Bruns. (12)
 Koenig, Bertram, 306 Broadway, Paterson (16)
 Koerber, George, 136 Prospect st., Passaic (16)
 Kohn, Joseph J., 207 Calhoun st., Trenton (11)
 Kolb, John M., 725 10th st., Union City (9)
 Kondor, Joseph S., 978 S. Broad st., Trenton (11)
 Konzelmann, Henry J., 65 King st., Hillside (20)
 Kooperman, Barnett, 321 16th st., W. New York (9)
 Kooperstein, Samuel I., 395 Ogden av., Jersey C'y (9)
 Koplin, Nathaniel H., 142 W. State st., Trenton (11)
 Koppel, Joseph A., 921 Bergen av., Jersey City (9)
 Kossmann, Walter J., Long Valley (14)
 Kovaleski, Walter A., 154 Passaic st., Passaic (16)
 Kovarsky, Albert E., 110 Market st., P'th Amboy (12)
 Kovin, Abraham, 123 Lexington av., Passaic (16)
 Kowalski, Louis J., 66 Fourth st., Passaic (16)
 Kraemer, Manfred, 31 Lincoln Park, Newark (7)
 Kraemer, Samuel H., 309 Baldwin av., Jersey C'y (9)
 Kraissl, Cornelius J., 393 Main st., Hackensack (2)
 Kraker, David A., 31 Lincoln Park, Newark (7)
 Kramer, Douglas W., 822 Park av., Plainfield (20)
 Kramer, Samuel E., 121 Market st., P'th Amboy (12)
 Krans, Clara DeH., 920 Park av., Plainfield (20)
 Krans, Edward S., 920 Park av., Plainfield (20)

Kratka, Wm. H., 119 N. Pearl st., Bridgeton (6)
 Krauss, Fletcher I., 201 Main st., Chatham (14)
 Krausz, Emery, 577 S. Main st., Phillipsburg (21)
 Kraut, Arthur M., 2801 Boulevard, Jersey City (9)
 Krechmer, Abraham, 521 Pacific av., Atlantic City (1)
 Kresch, Philip, 42 W. 22nd st., Bayonne (9)
 Kreutz, Paul J., 363 Union av., Elizabeth (20)
 Krohn, Marc, Campbell av., Belford (13)
 Kroll, Adolph, 103 Van Buren st., Passaic (16)
 Krone, William F., 31 Lincoln Park, Newark (7)
 Kruger, William, 31 Lincoln Park, Newark (7)
 Kuder, Joseph M., 104 Garden st., Mt. Holly (3)
 Kuchlewski, Edward J., 130 3rd st., Elizabeth (20)
 Kuhl, John P., 38 Main st., Butler (16)
 Kuhlmann, Alvin E., 527 37th st., Union City (9)
 Kuite, George B., 435 Speedwell av., Morris Plains (14)
 Kummel, Max, 31 Lincoln Park, Newark (7)
 Kun, Bertram, 135 Belmont av., Jersey City (9)
 Kushner, Alexander, 208 W. Milton av., Rahway (20)
 Kustrup, John F., 1418 S. Broad st., Trenton (11)
 Kutner, Charles, 1005 S. 5th st., Camden (4)

ASSOCIATE MEMBERS

Keith, Theodore R., 656 Bloomfield av., Nutley (7)
 Kelly, Leo J., 438 Amboy av., Perth Amboy (12)
 Klosk, Emanuel, 808 S. 12th st., Newark (7)
 Koeck, George P., 625 Mt. Prospect av., Newark (7)
 Koln, Ralph B., 207 Calhoun st., Trenton (11)
 Kohut, George J., 473 Amboy av., Perth Amboy (12)
 Koplin, A. Herman, 1239 Greenwood av., Trenton (11)
 Krafchik, Louis L., 100 Bayard st., New Brunswick (12)
 Kunz, Harold G., 82 W. Passaic av., Bloomfield (7)

ACTIVE MEMBERS

Laauwe, Harold W., 198 Haledon av., Paterson (16)
 Labash, Chas. S., 83 Quincy st., Passaic (16)
 Labow, Joseph J., 1063 E. Jersey st., Elizabeth (20)
 Ladas, George, 305 Cherry st., Elizabeth (20)
 Lafferty, Elton B., 330 Myrtle av., Irvington (7)
 Laird, George S., 127 Central av., Westfield (20)
 Lance, Elton W., 125 W. Milton av., Rahway (20)
 Landaw, Louis, 631 E. 26th st., Paterson (16)
 Landes, Edwin W., Stillwater (19)
 Landesman, William, 187 Kearny av., Kearny (7)
 Landis, Harry P., Jr., 925 Columbia av., Palmyra (3)
 Landshof, Charles A., 50 Glenwood av., Jer. City (9)
 Lane, Arthur G., Greystone Park (14)
 Lane, Austin W., 98 Prospect st., East Orange (7)
 Lane, Edgar W., 46 Main st., Bloomsbury (10)
 Lane, Thomas F., 155 Garrison av., Jersey City (9)
 Lange, Louis C., 50 Clifton ter., Weehawken (9)
 Lapin, Louis P., 15 Crosswicks st., Bordentown (11)
 Lapin, Samuel B., 542 W. State st., Trenton (11)
 Largay, Arthur O., 937 Ave. C, Bayonne (9)
 Larkey, Charles J., 700 Ave. C, Bayonne (9)
 Larossa, Ernest A., 640 Federal st., Camden (4)
 Larrabee, Callie H., 14 Kent pl. Blvd., Summit (20)
 Larson, Henry M., 35 Franklin st., Morristown (14)
 Larsson, Evert A., N. J. State Hosp., Trenton (11)
 Lathrop, Frederic W., 909 Park av., Plainfield (20)
 Lathrope, George H., 965 Broad st., Newark (14)
 Laurie, Andrew L., 664 Newark av., Elizabeth (20)
 Lavine, Barney D., 630 N. Clinton av., Trenton (11)
 Lavine, Sidney B., 134 W. State st., Trenton (11)
 Lawless, Edward T., 85 Warrington pl., E. Orange (7)
 Lawrence, Elias D., 365 Union av., Paterson (16)
 Lawrence, Wm. H., 129 Summit av., Summit (20)
 Lawsing, George C., 443 22nd st., W. New York (9)
 Lawther, B. M., 1401 Shore rd., Northfield (1)
 Lawton, A. Anderson, 15 N. Bridge st., Somerville (18)
 Lazow, S. Manlius, 199 Main st., Matawan (12)
 Leach, John E., 372 Park av., Paterson (16)

- Leaman, Granville M., 167 N. Grove st., E.Orange(7)
 Leaver, Morris H., Quakertown (10)
 Le Bel, Louis J. B., 165 Grant av., Nutley (7)
 Lee, Frederick P., 606 E. 27th st., Paterson (16)
 Lee, John J., 309 Park av., Orange (7)
 Lee, Stephen G., 55 Halsted st., East Orange (7)
 Lee, Thomas B., 622 Cooper st., Camden (4)
 Lefkowitz, Jacob H., 445 20th st., W. New York (9)
 Legato, Samuel F., 417 Palisade av., Cliffside P'k(2)
 Leggett, Lindley H., Jr., 330 E.Broad st.,Westf'd(20)
 Leggett, Thos. H., Jr., 937 Oakland pl., Plainfield(20)
 Lehmacher, Frank, 16 Central av., Lakewood (15)
 Lehman, Irving J., 558 Central av., Newark (7)
 Leibovitz, Altan C., 261 Lexington av., Passaic (16)
 Leighton, Robert L., 401 Ludlow av.,SpringLake(13)
 Leir, J. Krevin, 9 Garrison av., Jersey City (9)
 Lemay, Albert T., 532 14th av., Paterson (16)
 Lemmerz, Theodore H., 141 Magnolia av., Jer.C'y(9)
 Leonard, Edward F., 771 Madison av., Paterson (16)
 Leonard, George F., 63 N. 5th av., High'd Park(12)
 Leonard, Isaac E., 2842 Atlantic av., Atlantic City(1)
 Leonard, Lothair L., 615 Asbury av., Asbury P'k(13)
 Leonardis, James V., 94 Jefferson st., Newark (7)
 Lepree, Joseph A., 371 Morris av., Elizabeth (20)
 Lerman, Irving, 1024 E. Jersey st., Elizabeth (20)
 Lesko, Stephen W., 234 Mt. Pleas't av.,Wall'gt'n(2)
 Lettiere, Anthony J., 425 E. State st., Trenton (11)
 Levendusky, Daniel E., 52 Market st., Passaic (16)
 Levin, Joseph, 831 S. 13th st., Newark (7)
 Levin, Louis, 651 W. State st., Trenton (11)
 Levine, David B., 647 Broadway, Paterson (16)
 Levine, G. Irving, 2017 Hudson Blvd., Jersey City(9)
 LeVine, Israel, 215 Broadway, Paterson (16)
 Levine, Philip, 201 Lyons av., Newark (7)
 Levine, Sidney C., 459 Park av., Paterson (16)
 Levinsohn, Sandor A., 584 Broadway, Paterson (16)
 Levinson, Louis J., 18 Stratford pl., Newark (7)
 Levitas, Irving M., 388 Kinderkam'k rd., Westw'd(2)
 Levitt, Jesse N., 26 Clinton pl., Newark (7)
 Levy, Abram, Bound Brook (18)
 Levy, Herman, 219 Lexington av., Passaic (16)
 Levy, Irvin, 154 W. State st., Trenton (11)
 Levy, Julius, 19 Lyons av., Newark (7)
 Lewis, Albert, 41 Retford av., Cranford (20)
 Lewis, Alice B., E. Saddle River rd., E.SaddleRvr.(2)
 Lewis, G. Rae, 458 Washington av., Belleville (7)
 Lewis, Jacob, 43 Court st., Freehold (13)
 Lewis, Leon, 190 Clinton av., Newark (7)
 Lewis, Thomas K., 47 S. 27th st., Camden (4)
 Liccese, Emanuel, 84 Jefferson st., Newark (7)
 Licks, Fred'k C., 117 Irvington av., S. Orange (7)
 Lieb, Saul, 337 Hawthorne av., Newark (7)
 Lieberman, David P., 1063 North av., Elizabeth (20)
 Lieberman, Milton L., 101Pershing av.,RoselleP'k(20)
 Lief, Lawrence H., 41 Railroad av., Jamesburg (12)
 Lifland, Bernard D., 35 Shanley av., Newark (7)
 Lihn, Barney, 611 Elmer st., Vineland (6)
 Lilien, Bernard B., 730 Lyons av., Irvington (7)
 Linares, Angelo C., 208 Market st., Paterson (16)
 Lincoln, Jennings S., 140 Watch'ng av.,Up.M'tel'r(7)
 Linden, Mortimer H., 45 Clendenny av., Jer. City (9)
 Lindroth, Lawrence V., 620 Pavonia av., Jer. City(9)
 Lipkin, Isadore, 108 W. Main st., Pennsgrove (17)
 Lippincott, Lansing Y., 1058 Kenyon av.,Plainf'd(20)
 Lipshutz, Benjamin, 18 W. 22nd st., Bayonne (9)
 Lipshutz, Charles, 804 Ave. C, Bayonne (9)
 Lipton, Louis, 67 Passaic av., Passaic (16)
 Little, Alonzo W., 120 Arlington av., Jersey City(9)
 Little, Wm. R., 493 W. State st., Trenton (11)
 Littwin, Chas., 962 Queen Anne rd., Teaneck (2)
 Liva, Arcangelo, 5 Pangborn pl., Hackensack (2)
 Livengood, Baxter A., 406 Second st., Swedesboro(8)
 Livengood, Horace R., 587 Westminster av.,Eliz.(20)
 Livingston, Paul, 299 Main st., East Orange (7)
 Llull, Gabriel J., 266 Morris av., Springfield (20)
 Lobban, Robert B., 2595 Boulevard, Jersey City (9)
 Lobsenz, Nathan P., 294 Broadway, Paterson (16)
 Loder, Joseph S., 924 S. 17th st., Newark (7)
 Loeser, Lewis H., 31 Lincoln Park, Newark (7)
 Loman, Sam'l G.,Jefferson&Magn'lia avs.,Cressk'l(2)
 Lomauro, James R., 145 Lexington av., Passaic (16)
 London, Jules R., 153 Jefferson st., Passaic (16)
 London, William, 255 State st., Perth Amboy (12)
 Londrigan, Jos. F., 535 Washington st., Hoboken(9)
 Londrigan, Jos. F., II, 832Washing'tn st.,Hobok'n(9)
 Long, Miles T., 2150 Boulevard, Jersey City (9)
 Long, Pauline A., 22 Livingston av., N'wBruns.(12)
 Long, Wm. H., 40 S. Bridge st., Somerville (18)
 Longnecker, John E., Jr., Sparta (19)
 Longsdorf, Harold E., Mt. Holly (3)
 Longshore, Walter E., Jr., 216 Oakw'd av.,Orange(7)
 Looori, Wm. A., 549 Pavonia av., Jersey City (9)
 Lore, Harry E., Main st., Cedarville (6)
 Lorenzo, Michael J., 75 Riverside av., Red Bank(13)
 Losando, Camella A., 19 Prospect st., Summit (20)
 Lottridge, Dorothy, 43 S. Maple av., E. Orange (7)
 Love, Elizabeth F., 142 E. Oak av., Moorestown (3)
 Lovell, Fred'k H., 1013 Clinton av., Irvington (7)
 Lovett, Irving K., 110 E. Front st., Red Bank (13)
 Lovett, Jos. C., Municipal Hosp. Cont.Dis.,C'md'n(4)
 Low, Donald B., 529 Broadway, Paterson (16)
 Lowell, Milton E., 434 Summit av., Westfield (20)
 Lowenstein, Ernest C., 103 Elm st., Rahway (20)
 Lowenstein, Harry A., 96 Milford av., Newark (7)
 Lowrey, James H., 79 Congress st., Newark (7)
 Lowy, Otto, 190 Clinton av., Newark (7)
 Luban, Benjamin, 730 High st., Newark (7)
 Lucas, Wm. F., 23 W. Broad st., Burlington (3)
 Lucent, S. Bell, 2 First av., Little Falls (16)
 Luczynski, Edward W., 28 E. 22nd st., Bayonne (9)
 Lueddecke, Roland E.,216Randolph av.,E.R'th'rf'd(2)
 Lufburrow, Chas. B., 441 W. Front st., Plainf'd(20)
 Luippold, Eugene J., 85 Columbia ter., W'hawk'n(9)
 Luippold, Eugene J., Jr., 6Fielding court,S.Or'nge(7)
 Luksteid, Casimir J., 326 Park av., Paterson (16)
 Lummis, Clarence P., 40 Delaware av., Pennsgr.(17)
 Lund, John L., 267 High st., Perth Amboy (12)
 Lundblad, Walter E., 75 Prospect st., E. Orange (7)
 Luongo, Federico, 212 S. Centre st., Orange (7)
 Lupin, Edward E., 727 Ave. C, Bayonne (9)
 Luria, Sanford A., Bergen Pines, Oradell (2)
 Lurie, Wolf, 493 Watchung av., Bloomfield (7)
 Lushear, Frank H., Branchville (19)
 Lyerly, James M., 121 E. 7th st., Plainfield (20)
 Lynch, Albert E. O., 257 Orange rd., Montclair (7)
 Lynch, Edward T., 748 Livingston rd.,Elizabeth(20)
 Lynch, Maurice M., 396 Union st., Hackensack (2)
 Lynch, Roland J., Mental Dis. Hosp., Secaucus (9)
 Lynn, Irving I., 2252 Boulevard, Jersey City (9)
 Lyon, Archibald, 115 Ridge rd., N. Arlinton (7)
 Lyon, Earl C., 194 E. Commerce st., Bridgeton (6)
 Lyon, Leslie C., P. O. Box 63, Magnolia (4)
 Lyons, James V., 333 Park av., Orange (7)
 Lyons, Romola L. K., 171Mead'wbr'k rd.,Englew'd(2)

ASSOCIATE MEMBERS

- Lang, Joseph, 111B Market st., Perth Amboy (12)
 Lemmerz, Willard H., 164 Mortimer av.,Ruth'rf'd(2)
 Lemmon, Reuben, 241 State st., Perth Amboy (12)
 Levison, William, 75 Lincoln Park, Newark (7)
 Levy, Jack D., 801 N. Wood av., Linden (2)
 Lilien, Milton, 88 Norwood pl., Newark (7)
 Lord, C. Donald, 496 S. Maple av., Glen Rock (2)
 Lutz, Wm. M., 3 Southern Slope dr., Millburn (7)
 Lynch, Donald C., 178 W. State st., Trenton (11)

ACTIVE MEMBERS

- Mabey, J. Corwin, Clarem't & Mid'd avs., M'tcl'r(7)
 MacAlister, Wm. W., 171 Carroll st., Paterson (16)
 MacAlpine, Kenneth B., 308 Monm'th st., Gl'c'st'rC'y(4)
 Macaluso, Dominic C., 7 Hilton st., Belleville (7)
 MacArt, James H., 74 S. Munn av., E. Orange (7)
 MacArthur, Clymont, 219 Roseville av., Newark (7)
 Macaulay, Francis A., 815 Elm av., Teaneck (2)
 MacBrayer, Reuben A., 560 Morris av., Summit (20)
 MacDermid, Lynden E., 506 Fr'nsw'th av., B'rd'n't'n(11)
 Macdonald, Wentworth S., 56 Church st., M'tcl'r (7)
 MacDowall, John L., 113 Market st., P'thAmboy(12)
 Mace, Margaret, 2410 Atlantic av., N. Wildwood (5)
 MacFarland, Burr W., 419 W. State st., Trenton (11)
 MacGregor, Allan W., 379 Ellison st., Paterson (16)
 MacGuffie, Robert N., 657 Main av., Passaic (16)
 MacKellar, James M., 26 E. Clinton av., Tenafl'y (2)
 MacKenzie, Robert A., 501 Grand av., Asbury P'k(13)
 Mackes, Claude B., 48 N. Main st., Woodstown (17)
 Mackin, John J., 596 Bergen av., Jersey City (9)
 MacLay, Joseph A., 239 Broadway, Paterson (16)
 MacMillan, C. Wright, 23 Passaic av., Passaic (16)
 Macpherson, Elwood H., 34 Rawley pl., Millburn (7)
 Madaras, John S., 870 Ave. C, Bayonne (9)
 Madden, Leland S., 21 E. Verona av., Pl's'tville (1)
 Madden, Theophilus W., 16 Frazer av., Collingsw'd(4)
 Madden, William L., 83 Gifford av., Jersey City (9)
 Mader, Anthony I., Jr., 430 Union st., Hackens'k(2)
 Madison, Lewis K., 358 Pacific av., Jersey City (9)
 Maffongelli, Joseph A., 494 River st., Paterson (16)
 Magee, Harold S., N. J. State Hosp., Trenton (11)
 Magee, Russell S., 201 White Horse Pk., Audubon(4)
 Magennis, Bryan C., 272 Broadway, Paterson (16)
 Maggio, George A., 110 Fleming av., Newark (7)
 Maggio, Ross J., 550 Carlton rd., Westfield (20)
 Magill, Marcus, 4116 Ventnor av., Atlantic City (1)
 Magnes, Max, 271 Park av., Paterson (16)
 Magolda, Anthony F., 727 Grape st., Vineland (6)
 Magovern, Thos. F., 228 S. Orange av., S. Orange(7)
 Mahaffey, J. Lynn, 406 Warwick rd., Haddonfd(4)
 Maher, John E., 90 Third av., Long Branch (13)
 Mahood, Herbert L., 86 Durand rd., Maplewood (7)
 Majeski, Henry J., 935 Brunswick av., Trenton (11)
 Major, Morton M., 4212 Ventnor av., Atl. City (1)
 Makin, John B., 501 Grand av., Asbury Park (13)
 Malatesta, Chas. S., 302 E. 7th st., Plainfield (20)
 Maldeis, Albertos M. K., 117 N. 6th st., Camden (4)
 Mamlet, Alfred M., 16 Johnson av., Newark (7)
 Manahan, Daniel V., 55 E. Front st., Red Bank (13)
 Mancusi-Ungaro, Elviro, 268 Mt.Pr'sp't av., Nwk(7)
 Mancusi-Ungaro, Lodovico, 156 Mt.Pr'p't av., Nwk(7)
 Mangelsdorff, Arthur F., Calco Chem.Co.B'dBr'k(18)
 Mango, Concetta G., 1 31st st., N. Bergen (9)
 Mangone, Geo. F., 171 Palisade av., Union City (9)
 Manly, Thos. E., 390 Park av., Paterson (16)
 Mann, Benjamin, 468 Brace av., Perth Amboy (12)
 Mann, Jacob J., 255 State st., Perth Amboy (12)
 Manzione, Frank A., Pas'cCo.W'lfr'eH'me,Pr'kn's(16)
 Maps, Howard L., 53 Passaic av., Passaic (16)
 Maras, Peter E., 80 Tonnele av., Jersey City (9)
 Marcarian, Henry G., 904 Cooper st., Camden (4)
 Marchione, Nicholas E., 109 S. 7th st., Vineland (6)
 Marcus, Donald, 640 Stuyvesant av., Irvington (7)
 Marcy, John W., 117 E. Park av., M'rch'ntville (4)
 Margaretten, Edward I., 263 High st., P'thAmboy(12)
 Margolis, Alfred, 218 W. End av., Newark (7)
 Margulies, Charles, 188 High st., Nutley (7)
 Marini, Dominick, 40 Henry st., Passaic (16)
 Mark, Harry B., Riverton (3)
 Mark, Joseph S., 102 Green st., Woodbridge (12)
 Markel, Albert G., 450 Park av., Paterson (16)
 Markley, Luther A., Holy Name Hosp., Teaneck (2)
 Markowitz, Benjamin B., 2157 Blvd., Jersey City (9)
 Markowitz, Irwin B., 2157 Blvd., Jersey City (9)
 Markowitz, Louis, 16 Church st., Paterson (16)
 Marks, David M., 298 4th st., Jersey City (9)
 Marks, Edward G., 655 Kearny av., Arlington (7)
 Marks, Zelda I., 95 Wilson av., Newark (7)
 Marlett, Neumann C., 311 Front st., Belvidere (21)
 Marone, Carmine R., 648 1st av., Elizabeth (20)
 Maroney, James H., 129 Summit av., Summit (20)
 Marquis, Dean W., 144 Harrison st., E. Orange (7)
 Marquis, Wm. J., 198 Clinton av., Newark (7)
 Marra, Rocco S., 221 Park av., Orange (7)
 Marrocco, Wm. A., 47 Ward st., Paterson (16)
 Marsh, Elias J., 400 Van Houten st., Paterson (16)
 Marshall, Frank A., 440 Palisade av., Weehawken(9)
 Marshall, Henry D., 611 N. Indiana av., Atl. City(1)
 Marshall, Joseph C., 1517 Pacific av., Atl. City(1)
 Martin, Leonard J., 6 Borden av., Asbury Park (13)
 Martin, Theodore, 98 Haledon av., Paterson (16)
 Martin, Wm. P., 25 Holland rd., S. Orange (7)
 Martinetti, Carlo D., 311 Central av., Orange (7)
 Martland, Harrison S., City Hosp., Newark (7)
 Marvin, Dorothy H., 51 Livingston av., N'wBruns.(12)
 Mason, Howard B., 90 W. Main st., Freehold (13)
 Mason, James H., 1616 Pacific av., Atlantic City(1)
 Mason, Virgil A., 100 Chestnut st., E. Orange (7)
 Massengill, Fulton, 125 Harrison st., E. Orange (7)
 Massey, J. Bruce, 20 Codwise av., New Brunswick(12)
 Masterson, John F., 93 Myrtle av., Irvington (7)
 Mastro Monaco, Jos. D., 35 W. 34th st., Bayonne (9)
 Masucci, Alberico, 34 Ward st., Paterson (16)
 Matheke, George A., 592 Park av., East Orange (7)
 Matheke, Otto G., 328 Sussex av., Newark (7)
 Mathesheimer, Jacob L., 280 Old B'rg'n rd., Jer.C'y(9)
 Matheson, Gilchrist E., 144 Harrison st., E. Orange(7)
 Mathews, Raymond H., 186 South st., Morrist'n(14)
 Mathews, Wm. J., 938 Hudson st., Hoboken (9)
 Matthews, Clifford B., 1180 Raymond Blvd., N'w'k(7)
 Matthews, Harry E., 504 Hillside av., Orange (7)
 Matthews, Leonard M., 657 Main av., Passaic (16)
 Matthews, William, 139 Broad st., Red Bank (13)
 Matthews, Wm. F., 61 S. Fullert'n av., Montcl'r (7)
 Matturri, Dominick A., 174 Clinton av., Jersey C'y(9)
 Maturi, Vincenzo E., 814 Hudson Blvd., Bayonne(9)
 Maurer, K. Virginia, 26 W. Northfd rd., Liv'gst'n(7)
 Maver, William W., 532 Bergen av., Jersey City (9)
 May, Ernst A., 157 Harrison st., East Orange (7)
 Mayhew, Charles H., 329 Pine st., Millville (6)
 McBride, Andrew F., 30 Church st., Paterson (16)
 McBride, Hesser G., 1072 S. Orange av., Newark (7)
 McCall, Jesse, 12 Church st., Newton (19)
 McCallum, Arthur S., 213 Cl'm'tsBr.rd., Barr'gt'n(4)
 McCamey, Kenneth E., 612 E. 29th st., Paterson (16)
 McCandliss, Wm. K., State Hosp., Trenton (11)
 McCarthy, Arthur M., 2772 Federal st., Camden (4)
 McCarthy, George L., 506 Union av., Paterson (16)
 McCauley, Francis J., 31 Lincoln Park, Newark (7)
 McClintock, Elsie, 1439 Maple av., Hillside (20)
 McCluskey, Harry B., Parsippany rd., Whippany(14)
 McConaghy, Thos. P., cor.10th&Cooper sts., C'm'd'n(4)
 McConaughy, Francis, 1 E. High st., Somerville (18)
 McCorkle, William E., Ringoes (10)
 McCormack, Frank C., 95 Tenafl'y rd., Englew'd (2)
 McCormick, James E., 775 Elizabeth av., Newark(7)
 McCormick, Wm. H., Jr., 266 Market st., P'hAmby(12)
 McCoy, John C., 292 Broadway, Paterson (16)
 McCroskey, James H., 396 N. Arlington av., E.Or.(7)
 McCue, John B., 912 Lincoln av., Pompton Lks.(16)
 McCullough, John H., 523 E. State st., Trenton (11)
 McCullough, Walter A., Essex Co. Hosp., Cedar Gr.(7)
 McDannald, Wm. S., 41 Magnolia av., Tenafl'y (2)
 McDede, Frank F., 922 Main st., Paterson (16)
 McDede, J. Searle, 215 Ege av., Jersey City (9)
 McDermott, Vincent T., 511 State st., Camden (4)
 McDonald, Frank R., 37 Monticello av., Jer. City (9)
 McDonald, Richard J., 80 Park av., Paterson (16)

- McDonnell, George J., 80 W. Main st., Freehold(13)
McElroy, Ervin, 20 Main st., Rockaway (14)
McGeehan, Stanley M., Ryanhurst Apt.,Atl.City(1)
McGinn, Wm. J., 1913 Westfield av.,ScotchPls.(20)
McGlade, Thos. H., 2953 Yorkship Sq., Camden (4)
McGovern, John F., Jr.,24Liv'gst'n av.,N'wBrns.(12)
McGuigan, Francis A., 212 N.Warren st.,Tr'nt'n(11)
McIlvaine, Wm. E., 104 Third st., Lakewood (15)
McKelvie, Julius C., 55 Rockwell av., L'gBr'nch(13)
McKiernan, Robt. L., 97 Bayard st., N'wBruns.(12)
McKig, William F., 317 Roseville av., Newark (7)
McKinstry, John W., Railroad av., Jamesburg (12)
McLane, A. Donald, 498 Engle st., Englewood (2)
McLean, Herbert E., 92 Fairview av., Jersey City(9)
McLean, Hugh A., 414 17th st., W. New York (9)
McLellan, George A., 19 Hawthorne av.,E.Orange(7)
McLeod, Harry J., 71 Forest rd., Tenafly (2)
McLoughlin, Frank J., 558 Jersey av.,JerseyCity(9)
McMahon, Bernard C., 18 DeHart st., Morrist'n(14)
McMurray, Geo. B., N.J. StateHosp.,Gr'y'st'neP'k(14)
McMurtrie, William A., Far Hills (21)
McNenney, Claudio E., 113 Fairview av.,Jer.City(9)
McPherson, MalcolmE.,141Diam'dB.av.,H'wth'rne(16)
McTague, Robt. S., 9 Memorial Pky.,Atl.High'ds(13)
McVay, Edward A., 234 Lafayette st., Newark (7)
McVeigh, Charles J. D., Netcong (19)
McWilliams, Charles E., Blackwood (4)
Meacham, Eugene A., 112N.Stevens av.,S.Amboy(12)
Means, Paul B., State Hospital, Trenton (11)
Mears, Wm. G., 222 Overlook av., Leonia (2)
Mecray, Paul M., 405 Cooper st., Camden (4)
Medd, John C., 25 Curtis pl., Maplewood (7)
Meehan, George E., 117 Mercer st., Jersey City (9)
Meehan, Marjorie C., 24 Murray pl., Princeton (11)
Meehan, Martin M., 339 W'sh'gt'n av.,Belleville(7)
Meeker, Irving A., 581 Valley rd., Up. Montclair (7)
Meeker, John L., 6 DeBarry pl., Summit (20)
Meier, Wm. U., 1062 Ringwood av., Haskell (16)
Meineke, Wm. C., Jr., 820 Chestnut st., Roselle (20)
Meizer, Martin S., 147 Market st., Perth Amboy(12)
Mellen, Stanley H., 863 Mt. Prospect av., Newark(7)
Meloney, Lester F., 156 Second st., Clifton (16)
Meltsner, Louis, 904 Hudson st., Hoboken (9)
Meltzer, Louis, 32 W. 33rd st., Bayonne (9)
Mendelsohn, David H., 576 Broadway, Paterson(16)
Mendelsohn, Lewis, 272 Montgomery st., Jer.C'y(9)
Mendenhall, Clinton D.,412F'rnsw'th av.,B'r'd'n't'n(3)
Meneve, Alfred D., 373 Broadway, Paterson (16)
Menge, Carl H., 236 Washington st.,TomsRiver(15)
Mengel, Willard G., 400 Penn st., Camden (4)
Menk, Paul E., 31 Lincoln Park, Newark (7)
Merendino, Anthony G., 2720 Pacific av.,Atl.City(1)
Markelbach, Walter P., 288 Broad st., Bloomfield(7)
Merliss, Eugene, 386 Clinton av., Newark (7)
Merlo, Francis A., 210 Murray st., Elizabeth (20)
Merselis, John G., 110 Irvington av., S. Orange (7)
Mershheimer, Christian H., 15Reservoir av.,Jer.C'y(9)
Metz, Henry, 5 Pangborn pl., Hackensack (2)
Metzer, Emma P. W., 430 Fairview st., Riverside (3)
Metzer, Freeman W., 428 Fairview st., Riverside(3)
Metzger, Karl F., 603 Ninth av., Belmar (13)
Meurlin, Alfred, 158 S. Harrison st., E. Orange (7)
MeVay, James C. F., 2907 Pacific av., AtlanticC'y(1)
Meyer, George P., 410 Haddon av., Camden (4)
Meyer, Howard M., 400 Maple Hill dr., Hackens'k(2)
Meyer, William, 436 New York av., Union City (9)
Meyers, Francis R., 627 E. 24th st., Paterson (16)
Meyerson, Noah, 428 15th st., West New York (9)
Mezzetti, Alfred F., 220 S. 6th st., Vineland (6)
Michela, Luigi S., 206 Carroll st., Paterson (16)
Michell, George E., 221 High st., Hackettstown (14)
Mickewich, Stephen A., 650 Ave. C, Bayonne (9)
Miele, Frank A., 314 Carr av., Kearsburg (13)
Mierau, Ernest W., 1096 Sanford av., Irvington (7)
Miller, Earle K., 2502 Nottingham way,Trenton(11)
Miller, Gerald H., N. Main st., Cranbury (11)
Miller, Harry G., 203 E. Main st., Millville (6)
Miller, Herman P., 815 S. 12th st., Newark (7)
Miller, Jos. A., 364 Prospect st., S. Orange (7)
Miller, Lewis H., 37 S. Main st., Woodstown (17)
Miller, Max H., 311 16th st., West New York (9)
Miller, Ralph, 691 Elizabeth av., Newark (7)
Miller, Robert M., 382 Springfield av., Summit (20)
Miller, Samuel R., 407 S. Main st., Pennington (11)
Miller, Samuel T., 527 Bangs av., Asbury Park (13)
Miller, Theodore J., 527 N'w Brunsw'k av.,Fords(12)
Miller-Richardson, Emma, 581 Stevens st.,C'md'n(4)
Milligan, Robert S., 259 Morris av., Summit (20)
Mills, Alvah V., Lindsley rd., Little Falls (16)
Mills, Charles S., 106 Lippincott av., Riverton (3)
Mills, Clifford, 36 Maple av., Morristown (14)
Mills, Stephen D., 132 S. Euclid av., Westfield (20)
Milnis, Bernard, 100 30th st., Woodcliff (9)
Minard, Edwy L., 140 4th av., East Orange (7)
Mingham, Wm. D., 18 Hedden ter., Newark (7)
Minnefor, Chas. A., 1164 S. Orange av., S. Orange(7)
Minnella, Thomas J., 132 Morris av., Summit (20)
Mishell, Daniel R., 31 Lincoln Park, Newark (7)
Missonellie, Wm., 404 Lafayette av., Hawthorne(16)
Mitchell, Augustus J., 59 South st., Newark (7)
Mitchell, Chas. H., 1100 W. State st., Trenton (11)
Mitchell, Charles R., 311 Broadway, Paterson (16)
Mitskas, Theodore V. J., 704 Gr'nw'd av.,Trenton(11)
Mockett, Walter W., 714 Palisade av., Grantw'd(2)
Mockridge, Oscar A., 8 S. Mountain av., Montcl'r(7)
Moeckel, Clarence W., 63 S. Fullerton av.,M'tcl'r(7)
Moffat, Barclay W., Nut Swamp rd., Red Bank (13)
Mohr, Frank L., 1030 Pine av., Union (20)
Mohrbacher, John J., 37 Osborne ter., Newark (7)
Moister, Roger W., 7 Norwood av., Summit (20)
Molitch, Matthew, 705 Pacific av., Atlantic City (10)
Monaco, Saverio A., 293 Camden st., Newark (7)
Monaghan, Wm. J., Huds'n Co. Gen'lHosp.,S'c'c's(9)
Monasson-Friedland, Ida, Woodbine (5)
Moore, Dean C., 138 N. Arlington av., E. Orange (7)
Moore, Frank F., 201 Evergreen av., Woodlynne (4)
Moore, John D., 6 Washington st., Bloomfield (7)
Moore, Ralph L., 127 N. Broad st., Woodbury (8)
Moretti, John J., 576 S. Clinton st., E. Orange (7)
Morgan, Browne, 2 Broad st., Bloomfield (7)
Morici, Theodore, 80 Howe av., Passaic (16)
Moriconi, Albert F., 438 Hamilton av., Trenton (11)
Morley, Grace C., 64 Clifton ter., Weehawken (9)
Morrill, James P., 310 Broadway, Paterson (16)
Morris, Carlyle, Spring st. & Lake av., Metuchen(12)
Morris, Clement, 513 Broadway, Newark (7)
Morris, David G., 11 W. 26th st., Bayonne (9)
Morris, Thomas M., 503 Park av., Plainfield (20)
Morris, Watson B., 193 Morris av., Springfield (20)
Morrison, Caldwell, 379 7th av., Newark (7)
Morrison, Frederick H., Newton (19)
Morrow, Jos. R., Bergen Co. Hosp., Ridgewood (2)
Moschkowitz, Hermann, 737 High st., Newark (7)
Moscoe, Harry A., Main st., Lincoln Park (16)
Mosher, Henry L., 325 Valley Br'k av.,Lyndhurst(2)
Mott, Joseph E., 426 Park av., Paterson (16)
Motzenbecker, Peter F., 680 High st., Newark (7)
Motzenbecker, William J., 16 Milford av., Newark(7)
Moulton, Charles D., 122 Park av., East Orange (7)
Mount, Walter B., 21 Plymouth st., Montclair (7)
Muccia, John J., 7 Tonnele av., Jersey City (9)
Mueller, George H., 102 Summit av., Jersey City (9)
Muldoon, Edward J., 200 3rd st., Florence (3)
*Mulford, Ephraim R., 100 E. Broad st., Burl'gton(3)
Muller, Frederick L., 413 Third st., Carlstadt (2)
Mulligan, Luke A., 230 Central av., Leonia (2)
Mullin, Eugene F., 505 Sanford av., Newark (7)
Mullin, Raymond J., 76 Shanley av., Newark (7)

Mullins, Roy L., 305 Harrison st., Frenchtown (10)
 Mulvihill, Wm. J., 275 Hudson Blvd., Bayonne (9)
 Munger, Ray T., 727 Watchung av., Plainfield (20)
 Munro, Charles A., Marlton (3)
 Munro, Jeannette, 2 Queenston pl., Princeton (11)
 Murn, Charles J., 48 Smith st., Paterson (16)
 Murphy, Charles M., 21 Main st., Farmingdale (13)
 Murphy, Edward A., 1 Britton st., Jersey City (9)
 Murphy, Herschel S., 320 Chestnut st., Roselle (20)
 Murphy, James A., 142 N. Clinton av., Trenton (11)
 Murphy, James M., 2757 Boulevard, Jersey City (9)
 Murphy, Leo J., 374 West st., Union City (9)
 Murphy, Patrick H. W., 27 Jefferson av., Jer. C'y (9)
 Murray, Clifford K., 7103 Ventnor av., Ventnor (1)
 Murray, Edwin N., 558 Newton av., Camden (4)
 Murray, Harold A., 624 Mt. Prospect av., Newk (7)
 Murray, Joseph A., 765 Ave. C, Bayonne (9)
 Murray, Nelson T., 244 Stratford av., Westmont (4)
 Murray, Norman L., 129 Summit av., Summit (20)
 Murto, Thomas V., 532 W. State st., Trenton (11)
 Musetto, Carmelo A., 135 Cornelia st., Boonton (14)
 Mustermann, Otto H., 303 48th st., Union City (9)
 Muta, Samuel A., 47 Park av., West Orange (7)
 Mutchler, Julia C., 36 W. Blackwell st., Dover (14)
 Muttart, George W., 702 Ocean av., Jersey City (9)
 Mutter, Alfred A., 75 Beech st., Kearny (9)
 Myatt, Leslie E., 98 N. Pearl st., Bridgeton (6)
 Myers, Norman V., 301 Knickerbocker rd., Tenafly (2)

ASSOCIATE MEMBERS

Marx, Fred'k J., 281 W. Englew'd av., W.Engl'w'd (2)
 McBride, Andrew F., Jr., 655 B'dway, Paterson (16)
 Meinhard, Fred, 154 Van Buren st., Newark (7)
 Mitchelson, Henry, 557 Broadway, Paterson (16)
 Minschwaner, Geo. G., Jr., 954 Gr'nw'd av., Tr'n't'n (11)
 Moss, Mary C., 5 Mountain av., Maplewood (7)
 Mountford, Wm. E., 215 N. Warren st., Trenton (11)

ACTIVE MEMBERS

Nacca, Carl A., 86 N. Essex av., Orange (7)
 Nadel, Chas. I., 1186 Clinton av., Irvington (7)
 Nafash, Shafeek, 86 Palisade av., Union City (9)
 Nafey, Herbert W., 51 Livingston av., N'wBruns. (12)
 Nagler, Benedict, 25 Clinton pl., Newark (7)
 Nalitt, David I., 28 W. 33rd st., Bayonne (9)
 Napoli, Joseph D., 575 Summit av., Union City (9)
 Nappi, Pasquale E., 250 Mt. Prospect av., Newark (7)
 Nash, Alexander E., 30 Forest av., Verona (7)
 Nash, Herman S., 865 S. 11th st., Newark (7)
 Nash, William G., 20 Clinton st., Newark (7)
 Nataro, Joseph, 172 Littleton av., Newark (7)
 Naulty, Chas. W., Jr., 403 High st., P'thAmboy (12)
 Navazio, Attilio, 185 Speedwell av., Morristown (14)
 Neal, Chas. B., Pine & 3rd sts., Millville (6)
 Neer, William, 245 Broadway, Paterson (16)
 Neiderhoffer, Sydney L., 469 B'way, L'g Branch (13)
 Nelson, Harry, 36 Lupton av., Woodbury (8)
 Nemirow, Martin, 234 Lexington av., Passaic (16)
 Nemzek, Wm. P. B., 141 Ridge rd., N. Arlington (7)
 Nesbitt, Elizabeth, No. Jer. Tr'n'gSch'l, Little Falls (16)
 Netz, Lester W., 414 Main st., Hackensack (2)
 Nevius, William B., 610 Park av., E. Orange (7)
 Newbury, Graham C., 209 Holly st., Cranford (20)
 Newcomb, Marcus W., Browns Mills (3)
 Newman, Abraham J., 132 Manhattan av., Jer. C'y (9)
 Newman, Grace T., 339 Grove st., Montclair (7)
 Newman, Julius, 31 Lincoln Park, Newark (7)
 Newmeyer, Joseph, 701 Broadway, Camden (4)
 Ney, Julian M., 671 Broad st., Newark (7)
 Nichols, Frank I., 52 Euclid av., Hackensack (2)
 Nichols, Stanley H., 501 Grand av., Asbury Park (13)
 Nicholson, Frank P., 895 Summit av., Jersey City (9)
 Nickman, E. Harrison, 101 S. Newton av., Atl. C'y (1)

Nicol, Lorenz C., 360 Larch av., Bogota (2)
 Nicola, Toufick, 96 Gates av., Montclair (7)
 Nicoll, George L., 48 W. Blackwell st., Dover (14)
 Nieman, Solomon Z., 92 Bayard st., N'wBruns'k (12)
 Niemtzow, Frank, 55 E. Main st., Freehold (13)
 Nimaroff, Meyer, 265 Union av., Irvington (7)
 Nittoli, Rocco M., 660 E. Jersey st., Elizabeth (20)
 Noll, Louis, 1383 Clinton av., Irvington (7)
 Nonziato, Frank A., 50 Centre st., Trenton (11)
 Norris, Henry M., 144 Harrison st., E. Orange (7)
 North, Harry R., 160 W. State st., Trenton (11)
 Norton, James F., 58 Kensington av., Jersey City (9)
 Norval, William A., 419 Main st., Paterson (16)
 Norwich, Louis E., 355 Ave. C, Bayonne (9)
 Notkin, Meyer, 559 Broadway, Paterson (16)
 Noto, Philip, 158 Washington pl., Passaic (16)
 Novello, Joseph A., 641 Second av., Elizabeth (20)
 Nuse, Edward F., 550½ Jersey av., Jersey City (9)
 Nussbaum, Harvey E., 89 Ferry st., Newark (7)
 Nussbaum, Joseph, 321 Elmora av., Elizabeth (20)
 Nye, Howard H., 174 Carroll st., Paterson (16)
 Nyiri, William A., 30 Van Ness pl., Newark (7)

ASSOCIATE MEMBERS

Neary, Edward R., Palisades Park (2)
 Nicolais, Michael A., 346 Farnsw'th av., B'rd'nt'n (11)
 Normand, Alphonse F., 113 Market st., P'thAmb'y (12)

ACTIVE MEMBERS

Obert, Josiah E., Main st., New Egypt (15)
 Obester, Gabriel E., 646 Madison av., Elizabeth (20)
 O'Brian, Dennis M., 154 Lexington av., Passaic (16)
 O'Brian, Jeremiah H., 204 Madison st., Passaic (16)
 O'Brian, Paul, 196 Main st., E. Rutherford (2)
 Ockene, Abraham, 495 Palisade av., Union City (9)
 O'Connor, Bernard A., 314 N. 4th st., Harrison (7)
 O'Connor, Dennis F., 671 Broad st., Newark (7)
 O'Connor, John J., 434 New York av., Union City (9)
 O'Connor, Michael J., 98 Shanley av., Newark (7)
 O'Crowley, Clarence R., 31 Lincoln Park, Newark (7)
 Oderr, Charles, 659 Glen av., Westfield (20)
 O'Gorman, Michael W., 895 Bergen av., Jer. City (9)
 O'Grady, Benson J., 931 Washington st., Hoboken (9)
 O'Grady, Michael J., 228 Franklin av., Nutley (7)
 O'Hanlon, George, Medical Center, Jersey City (9)
 Okin, Irving, 165 Passaic av., Passaic (16)
 Older, Benjamin, 435 New York av., Union City (9)
 Oleynick, Simeon A., 107 Clinton av., Newark (7)
 Olini, Joseph J., 30 W. Market st., Newark (7)
 Olpp, Archibald E., 318 Bergenline av., Union City (9)
 Olpp, John L., 100 E. Palisade av., Englewood (2)
 O'Mara, John A., 314 St. Clair av., Spring Lake (13)
 O'Neill, Charles L., 11 N. 7th st., Newark (7)
 O'Neill, John H., 270 Montgomery st., Jersey City (9)
 Ondovchak, M. Fred'k, Kings H'way, Mt. Ephraim (4)
 Opdyke, Gordon M., 52 Claremont av., Verona (7)
 Opdyke, Levings A., 55 Clinton av., Jersey City (9)
 Openchowski, Mieczyslaw, 83 Johnson av., Newk (7)
 Opfermann, John L., 167 Bay av., Highlands (13)
 Oram, Joseph H., 495 Broadway, Paterson (16)
 Oren, Hyman, Park av., Park Ridge (2)
 Orloff, Samuel, 149 Lyons av., Newark (7)
 Ornaf, I. Edward, 1145 Thurman st., Camden (4)
 O'Rourke, James J., 871 Stuyvesant av., Trenton (11)
 Ortolano, James J., 159 First st., Hoboken (9)
 Orton, Foster, 196 Elm av., Rahway (20)
 Orton, George L., 196 Elm av., Rahway (20)
 Orton, Henry B., 24 Commerce st., Newark (7)
 Osborn, Adam D., 519 Sixth av., Belmar (13)
 O'Shea, John J., 438 Palisade av., Weehawken (9)
 Osher, Morris M., 194 Martine av., Fanwood (20)
 Oshrin, Henry, 750 Park av., West New York (9)

Osmun, Milton M., 611 Broadway, Camden (4)
O'Sullivan, John R., 33 Hamilton av., Kearny (9)
Ovens, Ritchie C., 675 Bergen av., Jersey City (9)
Owen, Logan S., 938 Hudson st., Hoboken (9)
Owen, Philip, 1273 Stuyvesant av., Union (20)

ASSOCIATE MEMBERS

O'Brien, William A., 158 Broadway, Passaic (16)
O'Connell, James J., 59 Easton av., New Brunswick (12)
O'Neill, Joseph F., Jr., 41 E. Broad st., Hopewell (11)
Opacity, Ernest A., 247 Madison av., Newark (7)
Oppen, Philip, 715 Broadway, Paterson (16)

ACTIVE MEMBERS

Pacicco, Michele, 376 Monmouth st., Jersey City (9)
Paddock, Royce, 965 Broad st., Newark (7)
Pagano, Peter, 45 N. Broad st., Ridgewood (2)
Pagliughi, John J., 401 18th st., Union City (9)
Pal, Darbari R., 32 Clark st., Paterson (16)
Palm, Howard F., 614 N. 2nd st., Camden (4)
Palma, Nicholas, 116 17th av., Paterson (16)
Palmer, Francis R., 249 Lexington av., Passaic (16)
Palmer, Gideon H., 28 Winans st., East Orange (7)
Palmer, Henry S., 275 Mulberry st., Newark (7)
Panigrosso, Louis R., 284 Wash'g'tn st., Philadelphia (12)
Panitch, William, 90 Baldwin av., Newark (7)
Pannell, Walter L., 243 E. Harrison st., E. Orange (7)
Pannullo, John N., 266 Van Buren st., Newark (7)
Pantaleone, Joseph, 504 Hamilton av., Trenton (11)
Papalia, Joseph A., 308 8th st., Union City (9)
Parent, Sol, 51 Baldwin av., Newark (7)
Paris, William, 518 E. 25th st., Paterson (16)
Parisi, Anthony, 296 S. Orange av., Newark (7)
Park, M. Benjamin, 360 Park av., Paterson (16)
Parker, Horace N., 72 N. Clinton av., Trenton (11)
Parker, James W., 175 Shrewsbury av., Red Bank (13)
Parker, John E., 144 Harrison st., East Orange (7)
Parry, Oliver K., 601 Bangs av., Asbury Park (13)
Parsonnet, Aaron E., 3 Madison av., Newark (7)
Parsonnet, Eugene V., 31 Lincoln Park, Newark (7)
Pascall, Thomas M., 197 Lincoln av., Newark (7)
Patella, Fulvio, 232 Broadway, Paterson (16)
Patterson, Isaac N., 230 Broadway, Westville (8)
Patti, Frank A., 304 Broad av., Leonia (2)
Pattysen, Ralph A., 144 Harrison st., E. Orange (7)
Paul, George A., 788 Lyons av., Irvington (7)
Paul, H. Carl, 30 Westville av., Caldwell (7)
Paulson, Arch M., 160 E. 7th st., Plainfield (20)
Pavia, John R., 95 N. Munn av., Newark (7)
Payne, Guy, Overbrook Hosp., Cedar Grove (7)
Payne, Guy, Jr., 56 S. Prospect st., Verona (7)
Payne, Joseph, 223 Godwin av., Midland Park (2)
Peacock, Arthur B., 39 W. Main st., Columbus (3)
Pearl, Sydney S., 545 Rahway av., Elizabeth (20)
Pearlman, Saul J., 210 Lexington av., Passaic (16)
Pearlstein, Frank, 325 16th st., W. New York (9)
Pearson, J. Gerald, 817 Washington st., Hoboken (9)
Pearson, Theodore A., Whitehouse (10)
Pedevill, Joseph R., 232 High'd av., Palisades Park (2)
Pedrick, William W., 11 West st., Glassboro (8)
Peer, Lyndon A., 965 Broad st., Newark (7)
Pegau, Paul M., 246 Briar Hill lane, Woodbury (8)
Pellarin, John D., 493 New York av., Union City (9)
Pellet, Thomas L., Hamburg (19)
Pellicane, Anthony J., 183 Liv'gst'n av., New Brunswick (12)
Pelusio, August N., 269 Carroll st., Paterson (16)
Penchansky, Samuel J., 847 Ave. C, Bayonne (9)
Pendexter, Sidney E., 11 S. Arlington av., E. Orange (7)
Pennington, Alfred W., 398 N. Maple av., E. Or. (7)
Pennington, John, 101 S. Indiana av., Atlantic City (1)
Pentel, Louis S., 307 16th st., West New York (9)
Perham, Bertram S., 199 Lorraine av., Up. Mt. Airy (7)

Perham, Roy G., 248 Boulevard, Hasbrouck Hgts. (2)
Perkel, Louis L., 2801 Hudson Blvd., Jersey City (9)
Perlberg, Harry J., 921 Bergen av., Jersey City (9)
Pernetti, Anthony M., 320 Broadway, Paterson (16)
Perrine, Cornelius C., 668 River rd., Fair Haven (13)
Perrone, Anthony J., 456 Roseville av., Newark (7)
Perrone, Arthur F., 415 16th st., West New York (9)
Perrotta, Anthony J., 94 Maple av., Red Bank (13)
Perry, Frank L., 43 East av., Woodstown (17)
Pessel, Johannes F., 224 W. State st., Trenton (11)
Peters, Edgar A. P., 394 Bergen av., Jersey City (9)
Peters, Richard C., 963 Park av., Plainfield (20)
Peterson, Charles A., 921 Wash'gton st., Hoboken (9)
Peterson, Walter R., 312 W. State st., Trenton (11)
Petry, William, 109 Treacy av., Newark (7)
Pettit, Harry H., 138 Franklin av., Ridgewood (2)
Pettit, Herschel, 807 Wesley av., Ocean City (5)
Phelan, Walter F., 124 Chilton st., Elizabeth (20)
Phelps, James E., 203 Park av., Paterson (16)
Phillips, Algernon A., 212 W. Market st., Newark (7)
Phillips, Claude B., 891 Haddon av., Collingswood (4)
Phillips, Walter, 109 E. Palisade av., Englewood (2)
Piasecki, Chester A., 741 E. 23rd st., Paterson (16)
Pieper, Howard C., 426 Bath av., Long Branch (13)
Pierce, H. A., 150 Broad av., Leonia (2)
Pierson, Carl L., 178 W. State st., Trenton (11)
Pierson, Joseph R., 10 E. Haddon av., Hopewell (11)
Pietri, Raoul, 501 Grand av., Asbury Park (13)
Pigott, Albert W., N. J. Vil. Epileptics, Skillman (18)
Pike, Charles E., 4 E. Haddon av., Oaklyn (4)
Pilch, Arthur G., 1 Willard av., Bloomfield (7)
Pilkington, Albert, 117 S. Virginia av., Atlantic City (1)
Piller, Jacob, 245 Broadway, Paterson (16)
Pilloni, Louis, 91 Beach st., Bloomfield (7)
Piltz, George F., 153 25th st., Guttenberg (9)
Pinckney, Frank H., 186 South st., Morristown (14)
Pindar, Fred'k S., 960 Park av., N. Bergen (9)
Pink, Solomon H., 21 High st., Butler (16)
Pinkerton, Wm. A., 854 Ave. C, Bayonne (9)
Pino, Anthony, 196 Irving av., Bridgeton (6)
Pinsky, M. Myer, 944 S. 5th st., Camden (4)
Piskorski, Abdon V., 604 Jersey av., Jersey City (9)
Pitkin, George P., 4 S. Wash'gton av., Bergenfield (2)
Pitman, Mason W. H., Belle Mead (18)
Pizzi, Francis W., 205 Park av., Orange (7)
Plant, James S., 502 High st., Newark (7)
Plante, Amos A., 437 Ridgewood rd., Maplewood (7)
Platt, Thomas H., 307 N. Wash'gton av., Dunellen (12)
Plavin, Nathan J., 5460 Hudson Blvd., N. Bergen (9)
Plinke, Fritz, 159 Lexington av., Passaic (16)
Plume, Clarence A., Main st., Succasunna (14)
Podell, A. Alfred, 51 E. Front st., Red Bank (13)
Pogoloff, Samuel H., Manville (18)
Pois, John, 52 Pillot pl., West Orange (7)
Polakoff, Joseph, Main st., Stirling (14)
Poland, George A., 206 E. Verona av., Plattsburgh (1)
Polishuck, Rubin, 127 Hollywood av., Hillside (20)
Policaastro, Nelson C., 378 Union st., Hackensack (2)
Polizzotti, Joseph L., 193 Park av., Paterson (16)
Pollak, Berthold S., 100 Clifton pl., Jersey City (9)
Pollis, Nicholas L., 642 High st., Newark (7)
Pollock, Franklyn J., 14 Watson av., Newark (7)
Polow, Benjamin, 24 Johnson av., Newark (7)
Polowe, David, 555 E. 27th st., Paterson (16)
Pomeranz, Raphael, 31 Lincoln Park, Newark (7)
Pons, Carlos A., 501 Grand av., Asbury Park (13)
Pontery, Herbert B., 89 Bowers st., Jersey City (9)
Posnock, Samuel M., 677 Ave. C, Bayonne (9)
Potter, Benjamin P., Hud. Co. T.B. San., Jersey City (9)
Potter, C., Belvidere av., Washington (21)
Potter, Ellen C., 301 W. State st., Trenton (11)
Potter, Raymond T., 144 Harrison st., E. Orange (7)
Pottinger, Wm. E., 6 Altamont court, Morristown (14)
Povalski, Alexander W., 1925 Boulevard, Jersey City (9)

Powis, Ethel M., 198 W. State st., Trenton (11)
 Poyas, Morton L., 306 W. State st., Trenton (11)
 Prager, Bert A., 251 Main st., Chatham (14)
 Prall, Henry E., Jr., 755 Anderson av., Cliffsides Pk (2)
 Prather, Charles G., 260 Westwood av., Westwood (2)
 Prather, John W., 155 Washington av., Dumont (2)
 Pratt, Arthur G., 516 Cooper st., Camden (4)
 Pratt, William H., 516 Cooper st., Camden (4)
 Pregnall, James P., 501 Grand av., Asbury Park (13)
 Prestifilippo, Silvestro, 115 Glen Ridge av., Mt. Clear (7)
 Preston, Perry B., 12 Palm st., Newark (7)
 Price, Chas. W., Essex Co. Hosp., Cedar Grove (7)
 Price, Nathaniel G., 16 Johnson av., Newark (7)
 Prigger, Edward R., 39 W. Main st., Pennsgrove (17)
 Prince, Robert A., 567 Broadway, Paterson (16)
 Principato, Roberto, 402 Walnut st., Camden (4)
 Probst, Everett W., 176 Camita av., Rutherford (7)
 Proctor, Francis E., 1245 Greenw'd av., Trenton (11)
 Prout, Thomas P., 19 Prospect st., Summit (20)
 Prout, Wm. B., 88 W. Forest av., W. Englew'd (2)
 Provisor, Benjamin, 141 Lexington av., Passaic (16)
 Pudney, Wm. K., 31 Trinity pl., Montclair (7)
 Purcell, Ernest F., 800 Stuyvesant av., Trenton (11)
 Purdy, Charles H., 35 Highland av., Jersey City (9)
 Pursell, Wm. D., 508 S. Main st., Phillipsburg (21)
 Pyle, Louis A., 89 Fairview av., Jersey City (9)
 Pyle, Wallace, 15 Exchange pl., Jersey City (9)

ASSOCIATE MEMBERS

Parell, George C., 275 S. 7th st., Newark (7)
 Parkes, Morey, 43 Forest av., Caldwell (7)
 Pasternack, Elroy, 255 Harrison st., Passaic (16)
 Pinto, Joseph A., 50 N. 11th st., Newark (7)
 Pittman, Allen R., N. J. State Hosp., Trenton (11)
 Pizzi, Mario V., 205 Park av., Orange (7)
 Placa, James A., 11 Ethelbert pl., Ridgewood (2)

ACTIVE MEMBERS

Quad, Clifford W., 52 Northfield av., West Orange (7)
 Quigley, Frederic J., 543 45th st., Union City (9)
 Quinby, William O., 14 James st., Newark (7)
 Quinn, John J., 921 Bergen av., Jersey City (9)
 Quinn, Norman J., 3303 Pacific av., Atlantic City (1)
 Quirk, Martin A., 90 W. Front st., Red Bank (13)

ACTIVE MEMBERS

Raab, Michael, 111 Lexington av., Passaic (16)
 Rader-Hoheb, Katherine A., 5 Lincoln av., Rutherford (2)
 Radest, Louis J., 158 Hamilton av., Paterson (16)
 Rado, William, 75 Lincoln Park, Newark (7)
 Rados, Andrew, 31 Lincoln Park, Newark (7)
 Ragany, Joseph, 966 S. Broad st., Trenton (11)
 Ragione, Mario D., 277 Clifton av., Newark (7)
 Rainey, Willard G., 34 Bayard lane, Princeton (11)
 Ram, Nathan H., 34 Park av., Caldwell (7)
 Rampona, Joseph M., 118 Nassau st., Princeton (11)
 Ramsey, F. Muriel, 310 E. Pine st., Millville (6)
 Randazzo, Anton P., 82 Prospect st., Passaic (16)
 Rankin, Stewart L., 61 S. River walk, Pennsgrove (17)
 Ranson, Briscoe B., Jr., 144 Harrison st., E. Orange (7)
 Rapp, Robert F., 302 S. Main st., Hightstown (11)
 Rathgeber, Chas. F., 18 William st., E. Orange (7)
 Raughley, William C., Taunton av., Berlin (4)
 Rauschenbach, Paul E., 225 Broadway, Paterson (16)
 Rauschenbach, Paul E., Jr., 174 Carroll st., Paterson (16)
 Ravitz, Samuel F., 1082 Broad st., Newark (7)
 Rawitz, Sidney B., 42 Chancellor av., Newark (7)
 Read, Hilton S., 5407 Atlantic av., Ventnor (1)
 Read, Jessie D., 519 Lenox av., Westfield (20)
 Read, Wm. T., Jr., Cooper Hosp., Camden (4)

Reale, Nicholas P., 119 S. Main st., Manville (18)
 *Rector, Joseph M., 681 Bergen av., Jersey City (9)
 Reeve-Allen, Jane, 254 Midland av., Montclair (7)
 Reeves, Ernest, 195 Lexington av., Passaic (16)
 Reeves, J. Franklin, 55 East av., Bridgeton (6)
 Reich, Abraham L., 83 Lyons av., Newark (7)
 Reich, Henry, 31 Lincoln Park, Newark (7)
 Reich, Jerome J., 1410 Maple av., Hillside (20)
 Reich, Samuel B., 348 Kinderkamack rd., Oradell (2)
 Reid, Erwin W., 125 Marsellus pl., Garfield (2)
 Reilly, Christopher J., 331 13th av., Newark (7)
 Reilly, John V., 520 Sanford av., Newark (7)
 Reiner, Jacob, 811 N. Broad st., Elizabeth (20)
 Reinfeld, Abraham G., 354 Clinton av., Newark (7)
 Reingold, Alexander, 221 Garden st., Hoboken (9)
 Reinhardt, Warren I., 276 Springdale av., E. Orange (7)
 Reinhold, Herb't E., 441 W. Englew'd av., W. Englew'd (2)
 Reisinger, Paul B., 369 W. State st., Trenton (11)
 Reissman, Erwin, 31 Lincoln Park, Newark (7)
 Reitnauer, John S., 518 44th st., Union City (9)
 Reitter, George S., 71 Harrison st., E. Orange (7)
 Relyea, George M., 129 Summit av., Summit (20)
 Remer, Daniel F., 417 High st., Mt. Holly (3)
 Renner, Clara C., N. J. State Hosp., Skillman (18)
 Renzulli, Francesco, 228 S. 7th st., Newark (7)
 RePass, Paul E., 85 Harrison st., E. Orange (7)
 Resch, Henry U., 27 Park pl., Bloomfield (7)
 Rettig, Isidor L., 36 Milford av., Newark (7)
 Revere, Seth D., 600 Park av., E. Orange (7)
 Reyner, Daniel C., 2703 Pacific av., Atlantic City (1)
 Reynolds, Donald G., 64 W. Main st., Freehold (13)
 Reynolds, Earle C., 655 Main av., Passaic (16)
 Reynolds, George G., 64 W. Main st., Freehold (13)
 Reynolds, Harry C., 657 Main av., Passaic (16)
 Rhoads, S. Creadick, 104 Station av., Westville (8)
 Rhone, David S., 1202 Haddon av., Camden (4)
 Ribbans, Robert C., 63 Central av., Newark (7)
 Rice, Franklin W., 184 South st., Morristown (14)
 Rich, Charles, 191 Littleton av., Newark (7)
 Rich, Wallace E., Essex Co. Hosp., Cedar Grove (7)
 Richards, Paul S., 1 Main st., Butler (16)
 Richardson, Arthur H., 60 Orange rd., Montclair (7)
 Richardson, Charles A., Main st., Closter (2)
 Richardson, Marvin T., 14 E. Mt. Pl's nt av., Livingston (7)
 Richter, Donald A., 185 Grand av., Englewood (2)
 Ricketts, Henry E., 31 Lincoln Park, Newark (7)
 Rieck, Allan, 507 S. Shore rd., Pleasantville (1)
 Rieck, Walter R., 379 Kearny av., Kearny (9)
 Rieman, Aloysius P., 3566 Hudson Blvd., Jer. City (9)
 Riese, Jacob A., 636 Palisade av., West New York (9)
 Riggins, Edwin N., 161 N. Arlington av., E. Orange (7)
 Rineberg, Irving E., 94 Bayard st., New Brunswick (12)
 Rinzler, Harry G., 127 Van Houten av., Passaic (16)
 Ripley, Charles D., 39 Lincoln Park, Newark (7)
 Ripley, Edward W., 56 Church st., Montclair (7)
 Rippes, Maurice L., 410 Elmora av., Elizabeth (20)
 Ristine, Edwin R., 123 Maple av., Westville (4)
 Rita, James J., 235 S. Clinton av., Trenton (11)
 Ritter, John J., 741 E. 22nd st., Paterson (16)
 Rizzolo, Edward M., 523 Union av., Belleville (7)
 Robbin, Lewis, 18 Clinton pl., Newark (7)
 Robbins, Charles M., 31 Lincoln Park, Newark (7)
 Robbins, Eugene, 909 Broad st., Newark (7)
 Robbins, Henry B., 144 Mercer st., Jersey City (9)
 Robbins, Warren D., 202 Ocean av., Cape May (5)
 Roberts, Allison H., 24 S. 9th st., Newark (7)
 Roberts, David C., 158 S. Harrison st., E. Orange (7)
 Roberts, Ebdon G., 1115 St. George st., Roselle (20)
 Roberts, Edgar W., 760 Palisade av., W. New York (9)
 Roberts, Frank A., 11 Park av., Caldwell (7)
 Roberts, Joseph E., Jr., 403 Cooper st., Camden (4)
 Roberts, William A., 11 Park av., Caldwell (7)
 Robertson, Euston S., 22 Harding ter., Kearny (7)
 Robertson, Grace M., 650 W. 7th st., Plainfield (20)

Robie, Theodore R., 144 Harrison st., E. Orange (7)
 Robins, David, 24 Commerce st., Newark (7)
 Robinson, Ernest A., 149 Atkins av., Asbury P'k(13)
 Robinson, John T., 598 Watchung rd.,BoundBr'k(18)
 Robinson, Louis H., 31 Lincoln Park, Newark (7)
 Robinson, Silas E., Franklin Tnpk., Waldwick (2)
 Robinson, Wm. A., 62 Main av., Ocean Grove (13)
 Rocco, Frank, 729 Summer av., Newark (7)
 Rodman, E. Warren, 503 Cooper st., Beverly (3)
 Roeber, William J., 21 Nesbit ter., Irvington (7)
 Roemer, Jacob, 213 Broadway, Paterson (16)
 Rogers, Dorothy M., 50 Cooper st., Woodbury (8)
 Rogers, Edward B., 814 Haddon av., Collingswd(4)
 Rogers, Harry L., 408 Main st., Riverton (3)
 Rogers, Laurence H., Municipal Hosp.,Trenton(11)
 Rogers, Richard M., 1 Wallace st., Newark (7)
 Rogers, Robert H., 49 9th av., Newark (7)
 Roh, Robert F., 671 Broad st., Newark (7)
 Roles, Earl W., 25 N. Harrison st., E. Orange (7)
 Romano, Patrick J., 203 S. Essex av., Orange (7)
 Rona, Maurice, 159 Bayard st., New Brunswick (12)
 Roop, Wm. O., 101 S. Indiana av., Atlantic City (1)
 Rosamilia, Ralph E., 480 N. 7th st., Newark (7)
 Rosecrans, James H., 826 Hudson st., Hoboken (9)
 Rosen, Chas. D., 106 S. Harrison st., E. Orange (7)
 Rosenberg, Albert B., 69 Myrtle av., Plainfield (9)
 Rosenberg, Alvin A., 22 High st., Morristown (14)
 Rosenberg, Jacob, 692 Bergen av., Jersey City (9)
 Rosenberg, L. Charles, 11 Murray st., Newark (7)
 Rosenberg, Louis, 26 S. Stenton pl., Atlantic City(1)
 Rosenberg, Max, 23 Wyndmoor av., Hillside (7)
 Rosenblatt, Sidney, 1904 Pacific av., Atlantic City(1)
 Rosenstein, Jacob L., 568 Bergen av., Jersey City(9)
 Rosenstein, Saivel L.,2120Springf'd av.,Vauxhall(20)
 Rosenthal, Sydney, 95 Wilson av., Newark (7)
 Rossell, Edward W., 801 Cooper st., Camden (4)
 Roth, Oswald H., 210 Littleton av., Newark (7)
 Rothfuss, C. Howard, 490 Rahway av.,W'dbridge(12)
 Rothhouse, Burnet, 31 Lincoln Park, Newark (7)
 Rothman, Theodore, 494 Park av., Paterson (16)
 Rothschild, Daniel L., 585 Elizabeth av., Newark(7)
 Rothschild, Karl, 149 Liv'gston av.,N'wBr'nsw'k(12)
 Rothseid, Abraham, 59 Avon av., Newark (7)
 Rothstein, Isadore B., 16 Lyons av., Newark (7)
 Rowan, Henry M., 224 W. State st., Trenton (11)
 Rowe, Norman L., 828 Grand st., Jersey City (9)
 Rowland, James J., 321 Bay av., Highlands (13)
 Rowland, John H., 159 New st., N'w Brunsw'k (12)
 Roy, Bert W., 25 Hamburg av., Sussex (19)
 Roy, Joseph N., 95 17th av., Paterson (16)
 Rube, Joseph A., 145 Prospect st., Ridgewood (2)
 Rubens, Otto, 27 E. Blackwell st., Dover (14)
 Rubenstein, Eli, 79 W. 32nd st., Bayonne (9)
 Rubin, Abraham A., 75 Lincoln Park, Newark (7)
 Rubin, Adrian D., 401 1st av., Asbury Park (13)
 Rubin, Henry S., 11 High st., Morristown (14)
 Rubinow, Saul M., 755 High st., Newark (7)
 Ruch, Louis, 129 Engle st., Englewood (2)
 Ruch, Valentine, 115 W. Palisade av., Englewood (2)
 Rucker, William C., 408 Main st., Hackensack (2)
 Rullman, Walter A., 58 W. Front st., Red Bank (13)
 Rundlett, Emilie V., 79 Prospect st., Jersey City (9)
 Runnells, John E., Bonnie BurnSana,ScotchPls.(20)
 Runyan, Wm. J., 102 Broad st., Bloomfield (7)
 Runyon, Laurance P., 80 Somerset st., N'wBrns.(12)
 Ruocco, William B., 416 River st., Paterson (16)
 Ruoff, Andrew C., 494 New York av., Union City (9)
 Rusby, Henry H., 143 Fifth st., Sarasota, Fla. (7)
 Russell, Chas. B., 119 Hamilton av., Paterson (16)
 Russell, David L., 690 Bergen av., Jersey City (9)
 Russo, Dominick T., 51 E. Somerset st., Raritan (18)
 Russomanno, Raymond L., 227Clifton av.,Newark(7)
 Ruttenberg, Louis, Union st., Mantua (8)

Ruttenberg, Max, 303 Cooper st., Camden (4)
 Ryman, Merlin T., 5 Dunbar st., Chatham (14)

ASSOCIATE MEMBERS

Rachlin, Harry T., 396 Union av., Irvington (7)
 Rechtman, A. M., 1217 Pacific av., Atlantic City(1)
 Reich, Mortimer, 31 Lincoln Park, Newark (7)
 Reilly, Thomas F., 187 Second st., Clifton (16)
 Reitman, Norman, 161 New st., New Brunswick(12)
 Ringe, Charles L., Jr., Palisade av., Teaneck (2)
 Ringewald, Robert H., 133 New York av., Jer. C'y(2)
 Rosenbaum, Samuel X., 96N.Walnut st.,E.Orange(7)
 Rosenthal, Arnold J., 263 Clinton pl., Newark (7)
 Rothgesser, Jerome C., 786 Bergen st., Newark (7)

ACTIVE MEMBERS

Sabarese, Theodore C., 122 Marsellus pl.,Garfield(16)
 Sacco, Anthony G., 440 New York av., Union City(9)
 Sacco, Gregory E., 191 Broad st., Red Bank (13)
 Sachs, Wilbert, 921 Bergen av., Jersey City (9)
 Sadoff, Joseph, 116 Elmora av., Elizabeth (20)
 Saffron, Morris H., 292 Paulison av., Passaic (16)
 Salasin, Samuel L., 511 Pacific av., Atlantic City(1)
 Salvati, Leo H., 244 Walnut st., Westfield (20)
 Salway, Benjamin, 321 S. Broad st., Trenton (11)
 Salzman, Nathan, 714 Broadway, Paterson (16)
 Samson, Norman D., 281 Kearny av., Kearny (7)
 Samuels, Sol L., 219 W. 7th st., Plainfield (20)
 Sandella, Joseph F., 169 New st., New Brunsw'k(12)
 Sandler, Moses, 1630 Center av., Fort Lee (2)
 Sandler, Samuel A., Hospital pl.&Atl.st.,Hack'ns'k(2)
 Sanfacon, Thomas A., 340 Park av., Paterson (16)
 Santangelo, Emil L., 349 Broadway, Paterson (16)
 Santangelo, Stephen, 461 Jersey av., Jersey City(9)
 Santor, G. Frank, 3176 Westfield av., Camden (4)
 Santora, Philip J., 361 Roseville av., Newark (7)
 Santosky, Benjamin B., 143 Bergen av., JerseyC'y(9)
 Saradarian, Albert V., 481 NewYork av.,UnionC'y(9)
 Sarla, Michael, 55 Hudson st., Hackensack (2)
 Saslow, Benjamin I., 680 Clinton av., Newark (7)
 Sasso, Albert, 99 Parker st., Newark (7)
 Satulsky, Emanuel M., 652 Park av., Elizabeth (20)
 Saulsberry, Chas. E., 75 Livingston av.,N.Bruns.(12)
 Saunders, Orris W., 1700 Broadway, Camden (4)
 Sawyer, Blackwell, 109Wash'gton st.,TomsRiver(15)
 Sax, Max T., 84 Grove st., Bloomfield (7)
 Sayre, William D., 69 Maple av., Red Bank (13)
 Sbarra, Francesco C. N., 189 Roseville av., New'k(7)
 Scaccia, Alfred C., Bound Brook (18)
 Scammell, Frank G., 40 S. Clinton av., Trenton (11)
 Scanlan, D. Ward, 15 S. Illinois av., Atlantic C'y(1)
 Scasserra, Benedict B., 163 Nassau st.,Princeton(11)
 Schaaf, Royal A., 413 Mt. Prospect av., Newark (7)
 Schachter, Harry A., 6 Milford av., Newark (7)
 Schaefer, Eugene P., 12 Harrison pl., Irvington (7)
 Schaffer, Barney, 252 Washington av., Belleville (7)
 Schaffer, Nathan, 172 S. Arlington av., E. Orange(7)
 Schall, Reuben E., 537 N. 7th st., Camden (4)
 Scheetman, Vera, 385 Osborne ter., Newark (7)
 Scheffler, Wilhelm A. H., 511 Cooper st., Camden (4)
 Schefrin, Alex E., 235 Lexington av., Passaic (16)
 Schellenger, Edward A. Y., 429 Cooper st.,Camden(4)
 Scheller, George A., 701 Clinton av., Newark (7)
 Schenk, Joseph R., 1177 Park av., Plainfield (20)
 Schenker, Benjamin N., 246 5th st., Jersey City (9)
 Schept, Samuel S., 523 37th st., Union City (9)
 Scher, Maurice A., 137 Lyons av., Newark (7)
 Schiffmann, Samuel, 107 Spruce st., Newark (7)
 Schildkraut, Jacob M., 170 W. State st., Trenton(11)
 Schiller, Edwin, 449 Westminster av., Elizabeth (20)
 Schiller, Rosa O., 449 Westminster av., Elizab'h(20)
 Schiller, Nicholas, 29 Girard pl., Newark (7)

- Schilling, Anthony B., 727 Jefferson av., Elizab'h(20)
 Schisler, Milton M., 2nd & Church sts., Florence (3)
 Schlein, August, 707 Park av., Hoboken (9)
 Schlein, David, 26 E. Price st., Linden (20)
 Schlichter, Chas. H., 556 N. Broad st., Elizabeth (20)
 Schlossbach, Theodore, 94 S. Main st., Ocean Gr.(13)
 Schmidt, Albert F., 81 Union av., Manasquan (13)
 Schmidt, Walter W., 386 Palisade av., CliffsideP'k(2)
 Schmukler, Jacob, 29 Rutgers st., Maplewood (7)
 Schneider, Charles A., 694 Clinton av., Newark (7)
 Schneider, Clinton R., 125 N.Green st.,Tuckerton(15)
 Schneider, Louis, 874 S. 13th st., Newark (7)
 Schneider, Louis A., 412 17th st., W. New York (9)
 Schoenau, Carl W., 1255 Broad st., Bloomfield (7)
 Schotland, Clement E., 41 Leslie st., Newark (7)
 Schrack, Helen F., 216 N. 5th st., Camden (4)
 Schramm, Joseph A., 572 High st., Newark (7)
 Schreck, Harry, 192 Roseville av., Newark (7)
 Schroeder, Henry J. L., Hotel Windsor,Trenton(11)
 Schubert, Roy R., 408 Union av., Paterson (16)
 Schuchner, Wm. F., 550½ Jersey av., Jersey City(9)
 Schuck, Traugott J., 58 9th st., Hoboken (9)
 Schulman, Abraham S., 4638 Blvd., Union City (9)
 Schulman, Robert, Aurora HealthInst.,Morrist'n(14)
 Schulsinger, Samuel, 80 Clinton av., Newark (7)
 Schulte, Herbert A., 701 Clinton av., Newark (7)
 Schultz, Anna R., 207 Summer av., Newark (7)
 Schultz, Augustin M., 379 Union av., Paterson (16)
 Schurman, Francis H. C., 14 Smull av., Caldwell (7)
 Schwartz, Henry C., Raritan av., Atco (4)
 Schwartz, Samuel H., 1044 Park av., Plainfield (20)
 Schwartz, William, 155 Lexington av., Passaic (16)
 Schwartzberg, Frederick I., 522 B'way, Paterson(16)
 Schwarz, Berthold T. D., 2787 HudsonBlvd.,Jer.C.(9)
 Schwarz, Henry J., 5560 Hudson Blvd., N. Bergen(9)
 Schwarzkopf, George C., 2901 Pacific av.,Atl.City(1)
 Schwin, Chas., 7600 Winchester av., MargateC'y(1)
 Scielzo, Nicholas F., 369 Park av., Paterson (16)
 Scott, Elmer A., Belle Mead Sana., Belle Mead (13)
 Scott, Frederick J., 1 Oak st., Franklin (19)
 Scott, Fred'k W., 103 Bayard st., New Brunsw'k(12)
 Scott, Harold R., 10 Speedwell av., Morristown (14)
 Scott, Jos. H., 121 N. Virginia av., Atlantic City (1)
 Scott, Karl M., 1616 Pacific av., Atlantic City (1)
 Scott, Parry M., 466 Cooper st., Beverly (3)
 Scott, R. Hunter, 205 Roseville av., Newark (7)
 Scott, Samuel G., 141 Bergen av., Jersey City (9)
 Scranton, Chas. W., 59 Wash'gton st., E. Orange(7)
 Scribner, Chas. H.,R.F.D.No.1,H'mb'gTpk.,Pr'kn's(16)
 Scruggs, Wm. J., 3005 Kearsarge rd., Camden (4)
 Scudder, Frank D., 65 N. Fullerton av.,Montclair(7)
 Scullion, Arthur A., 460 Anderson av.,CliffsideP'k(2)
 Sealey, Henry J., 79 Washington av., Dumont (2)
 Seely, Roy B., 78 N. Clinton av., Trenton (11)
 Segard, Christian P., 204 Glenwood av., Leonia (2)
 Seidler, Victor B., 16 Plymouth st., Montclair (7)
 Seidman, Edwin A., 580 High st., Newark (7)
 Seifert, Edwin A., 415 Ridgew'd av., Glen Ridge(7)
 Seiler, Benjamin, 330 Palisade av., Cliffside Park (2)
 Seitzick-Robbins, HannahE.,733H'milt'n av.,Tr'n(11)
 Sekerak, Albert J., 984 S. Broad st., Trenton (11)
 Selinger, Samuel, 413 16th st., West New York (9)
 Sell, Frederick W., 167 W. Emerson av.,Rahway(20)
 *Sellers, Robert R., 19 Chestnut st., Newark (7)
 Selvaggi, Carlo, 82 Congress st., Newark (7)
 Sender, Fannie, 193 Main st., South River (12)
 Senerchia, Fred F., Jr., 604 W'stm'st'r av., Eliz. (20)
 Sewall, Millard F., 195 E. Commerce st.,Bridgeton(6)
 Seward, Frederic H., 40 Gr'n Village rd.,Madison(14)
 Seward, Wm. H., Orange Mem'l Hosp., Orange (7)
 Sewell, Stephen, 320 Passaic av., Spring Lake (13)
 Sexsmith, George H., 719 Ave. C, Bayonne (9)
 Sexton, Edward V., 936 Queen Anne rd., Teaneck(2)
 Seybold, Arthur D., 302 E. 7th st., Plainfield (20)
 Seymour, Edward T., 55 Hillside av., Tenafly (2)
 Seymour, George A., 253 Orchard st., Elizabeth (20)
 Shack, David N., 712 Clinton av., Newark (7)
 Shack, Maxwell H., 17 Lyons av., Newark (7)
 Shafer, Albert H., 405 Cooper st., Camden (4)
 Shafer, F. William, 634 Penn st., Camden (4)
 Shaner, Ralph D., 94 Hillside av., Nutley (7)
 Shangle, Milton A., 34 Prince st., Elizabeth (20)
 Shanik, Wm., 600 4th av., Asbury Park (13)
 Shannon, Jas. B., 66 S. Fullerton av., Montclair (7)
 Shannon, Lardner M., 66 S. Fullerton av., M'tcl'r(7)
 Shapiro, Charles S., Maple Shade (3)
 Shapiro, David, 707 Broadway, Paterson (16)
 Shapiro, Louis, 146 Broad st., Newark (7)
 Shapiro, Louis G., 375 Broadway, Paterson (16)
 Shapiro, Maurice, 750 Ave. C, Bayonne (9)
 Shapiro, Saul J., 192 Palisade av., Union City (9)
 Sharp, Charles E., Main st., Port Norris (6)
 Sharp, Jennie S., 719 Cooper st., Camden (4)
 Sharp, Reuben L., 719 Cooper st., Camden (4)
 Shaul, Fred'k G., 10 Washington st., Bloomfield (7)
 Shavelson, Irving C., 3822 Ventnor av., Atl. City(1)
 Shaw, Ernest B., 811 Collings av., W. Collingsw'd(4)
 Shaw, John J., 127 Scheerer av., Newark (7)
 Sheaffer, Clinton P., 241 Kings H'way,E.Had'nf'd(4)
 Shear, Maurice M., 1158 E. State st., Trenton (11)
 Sheehan, Daniel C., 12 Cliff st., Newark (7)
 Sheeran, Vincent J., 269 Jewett av., Jersey City (9)
 Sheets, Cecil C., 213 W. Broad st., Paulsboro (8)
 Shemeley, William G., Jr., 7 Haddon av., Camden(4)
 Shenfeld, Isaac, 4806 Atlantic av., Ventnor (1)
 Sheppard, A. G., 309 Broad st., Elmer (6)
 Sheppard, Frank R., 131 N. 3rd st., Millville (6)
 Sheppard, Muse A., Penn & Broad sts., Elmer (6)
 Sher, A. Lincoln, 2647 Westfield av., Camden (4)
 Sherman, A. Russell, 671 Broad st., Newark (7)
 Sherman, Allton L., 485 Park av., Orange (7)
 Sherman, Arthur E., 243 S. Harrison st.,E.Orange(7)
 Sherman, Benjamin, Aurora H'th Inst.,M'rrist'n(14)
 Sherman, Byron G., 52 Maple av., Morristown (14)
 Sherman, Elbert S., 671 Broad st., Newark (7)
 Sherman, Fuller G., 53 Newton av., Woodbury (8)
 Sherman, Samuel H., 81 Elmora av., Elizabeth (20)
 Sherman, Wm. E., 88 Schureman st., NewBrun.(12)
 Shill, Benjamin, 738 High st., Newark (7)
 Shimer, A. Burton, 606 Pacific av., Atlantic City(1)
 Shimer, Floyd A., 88 Lewis st., Phillipsburg (21)
 Shipman, James S., 542 Cooper st., Camden (4)
 Shipman, Meyer P., 237 Broadway, Paterson (16)
 Shippee, David N., 648 Ringwood av., Wanaque(16)
 Shippee, James N., 648 Ringwood av., Wanaque (16)
 Shipps, Hammell P., 739 Chestnut st., Delanco (3)
 Shirlock, Margaret E., Vinel'dTr'ningSch'l,Vinel'd(6)
 Shirrefs, Russell A., 348 Elmora av., Elizabeth (20)
 Shivers, Charles H. deT., 121 S. Illinois av.,Atl.C.(1)
 Shook, Benjamin E., 284 Bergen av., Jersey City(9)
 Shope, Edward P., 511 Cooper st., Camden (4)
 Shor, David M., 32 S. Munn av., E. Orange (7)
 Shore, Ernest L., 306 Atlantic av., Atlantic City(1)
 Shreehan, Hubert F., 620 Summer av., Newark (7)
 Shull, Elliott C., 517 Cooper st., Camden (4)
 Shull, John V., 84 Market st., Perth Amboy (12)
 Shulman, Abraham, 528 E. 29th st., Paterson (16)
 Shulman, Murray W., 916 S. 20th st., Newark (7)
 Shulman, Nathan L., 538 45th st., Union City (9)
 Sica, L. Samuel, 431 E. State st., Trenton (11)
 Sickel, Emanuel M., 220 Madison av., Lakewood (15)
 Sieber, Isaac G., 204 Merchant st., Audubon (4)
 Siegel, Isadore, 121 Market st., Perth Amboy (12)
 Siegel, Jacob W., 96 S. 10th st., Newark (7)
 Siegel, Sidney L., 227 N. Second st., Millville (9)
 Siegler, Julius, 646 Bergen av., Jersey City (9)
 Siemion, Theophilis R., 1005Brunsw'k av.,Tr'nt'n(11)
 Silich, Robert L., 27 4th st., Weehawken (9)

- Silk, Charles I., 278 High st., Perth Amboy (12)
Sill, John B., 942 W. State st., Trenton (11)
Silver, E. Drew, 136 Stockton st., Hightstown (11)
Silver, Geo. A., 242 Stockton st., Hightstown (11)
Silver, Harry B., 190 Clinton av., Newark (7)
Silverman, Irving A., 260 Dayton av., Clifton (16)
Silverman, R. Louis, 3 Franklin st., Pennsgrove (17)
Silvers, Homer I., 16 S. Suffolk av., Ventnor (1)
Silverstein, Benjamin J., 32 Hillside av., Newark (7)
Silverstein, Jacob M., 73 Main st., Millburn (7)
Silverstein, Max, 605 First av., Asbury Park (13)
Simeone, Peter A., 555 38th st., Union City (9)
Simkin, Abraham, 247 Broadway, Passaic (16)
Simmons, Albert V., 720 Prospect st., Maplewood (7)
Simms, George F., 541 Page av., Lyndhurst (7)
Simon, Henry, 5 Vermont av., Newark (7)
Simon, Julius J., 174 Columbia av., Passaic (16)
Simon, Ludwig L., 201 Ferry st., Newark (7)
Simon, Morris L., 174 Washington pl., Passaic (16)
Simon, Philip H., 174 Columbia av., Passaic (16)
Simpson, David B., 9 E. 35th st., Bayonne (9)
Sims, Richard V., Jr., 21 Morris av., Summit (20)
Sinexon, Henry L., 36 W. Broad st., Paulsboro (8)
Singer, Bella, 406 Elmora av., Elizabeth (20)
Singer, Max, 147 Johnson av., Newark (7)
Singer, Sina S., 3443 Boulevard, Jersey City (9)
Singley, Harry P., Jr., 101 S. Buffalo av., Ventnor (1)
Sinkinson, Chas. D., Jr., 1616 Pacific av., Atl. City (1)
Sinton, John Y., Imlaystown (11)
Sirott, Barnett H., 413 State st., Perth Amboy (12)
Sirota, E. Bernard, 220 W. Broad st., Paulsboro (8)
Sisson, Nelson W., 144 Harrison st., E. Orange (7)
Siveke, John, 106 Lexington av., Passaic (16)
Skvarla, John A., 17 Koster st., Wallington (2)
Skwirsky, Joseph, 170 Hawthorne av., Newark (7)
Slack, Clarence J., 230 W. State st., Trenton (11)
Slaff, Florence, 16 Grove st., Passaic (16)
Slavin, Paul, 31 Lincoln Park, Newark (7)
Sloan, Samuel L., 182 Belmont av., Paterson (16)
Slobodien, Benjamin F., 107 Market st., P'th Amb'y (12)
Slocum, Harry B., 263 Bath av., Long Branch (13)
Sly, John L., 382 Springfield av., Summit (20)
Smaine, Enrique del C., 502 Summit av., Carlstadt (2)
Small, E. Lester, 30 Branch st., Medford (3)
Smalley, Mahlon C., Gladstone (18)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smalzried, Elmer W., 69 Woodland av., E. Orange (7)
Smith, A. L. M., 62 Bayard st., New Brunswick (12)
Smith, Alexander L., 2672 Boulevard, Jersey City (9)
Smith, Andrew M., 344 Phil'd'phia av., Egg H'r'b'r (1)
Smith, Arthur B. R., 13 Fairmount ter., Jer. C'y (9)
Smith, Bertram H., 315 W. Kings H'way, Audubon (4)
Smith, Byron J., 851 S. Orange av., E. Orange (7)
Smith, Carroll D., 320 Broadway, Paterson (16)
Smith, Christopher A., 6 Park st., Roseland (7)
Smith, Ellis L., Soho Hospital, Belleville (7)
Smith, Elroy W., 655 Main av., Passaic (16)
Smith, Geo. H., 136 Evergreen pl., East Orange (7)
Smith, Harold W., 179 Lincoln av., Orange (7)
Smith, Henry G., Essex Co. Hosp., Cedar Grove (7)
Smith, Herman, Phillipsburg (21)
Smith, Houghton C., 1063 S. Clinton av., Trenton (11)
Smith, Ivan B., Pittstown (10)
Smith, James D., 701 N. 6th st., Camden (4)
Smith, J. Meredith, 212 Grand av., Hackettstown (21)
Smith, John V., 463 State st., Perth Amboy (12)
Smith, Joseph J., 325 13th av., Newark (7)
Smith, Leon A., 655 Main av., Passaic (16)
Smith, Leonard H., 32 Washington st., E. Orange (7)
Smith, Malcolm K., 22 Madison av., Morristown (14)
Smith, Marcia V., 821 Wesley av., Ocean City (5)
Smith, Nehemiah E., 33½ Humphrey st., Engl'w'd (2)
Smith, Paul E., State Hospital, Trenton (11)
Smith, Percy L., George's rd., Dayton (12)
Smith, Thayer A., Forest dr. & Park pl., Short Hills (7)
Smith, Warren H., 91 Main st., Newton (19)
Smith, Wilbur A., 2 E. Clinton av., Oaklyn (4)
Smith, W. Henley, 126 W. State st., Trenton (11)
Snaveley, Earl H., City Hospital, Newark (7)
Snedecor, Spencer T., 50 Anderson st., Hack'n's k (2)
Negreff, Leonid S., 14 Waverly pl., Trenton (11)
Snyder, John E., 1023 Garden st., Hoboken (9)
Snyder, Wm. J., 74 Columbia ter., Weehawken (9)
Sobel, Irving J., 136 Broadway, Passaic (16)
Sobin, Julius, 24 Waverly av., Newark (7)
Sochacki, Alexander, 1478 Mt. Ephr'm av., Camden (4)
Sokal, Henry B., Manville (18)
Solk, Arthur G., 88 Clinton av., Newark (7)
Solworth, Lee, 100 E. Palisade av., Englewood (2)
Somers, Fred L., 144 Harrison st., E. Orange (7)
Sommer, George N. J., 120 W. State st., Trenton (11)
Sommer, George N. J., Jr., 120 W. State st., Trent'n (11)
Sooy, Leslie T., 202 W. Holly av., Pitman (8)
Soschin, Samuel J., 31 Lincoln Park, Newark (7)
Spallone, Jos. C., 123 Mt. Prospect av., Newark (7)
Spano, Frank, 320 47th st., Union City (9)
Sparks, Paul R., 21 W. Broad st., Burlington (3)
Spath, George B., 722 Hudson st., Hoboken (9)
Spence, Henry, 2540 Boulevard, Jersey City (9)
Spencer, Alvan, 395 W. Blackwell st., Dover (14)
Spencer, Ira T., 152 Main st., Woodbridge (12)
Spencer, Jas. H., Jr., 23 Hospital rd., Franklin (19)
Spickers, William, 6 Church st., Paterson (16)
Spillane, Timothy H., 379 S. Main st., Phillipsb'g (21)
Spinner, Samuel L., 66 Goldsmith av., Newark (7)
Spirito, Michael W., 1071 Elizabeth av., Elizab'th (20)
Spivack, David, 944 E. Jersey st., Elizabeth (20)
Spohn, Eugene L., 921 Bergen av., Jersey City (9)
Spradley, Jeems B., State Hospital, Trenton (11)
Sprague, Edward W., 86 Washington st., Newark (7)
Sprague, Seth B., 301 York st., Jersey City (9)
Spritzer, Theo. D., S. Washington av., Dunellen (12)
Spurgeon, Dorsett L., 19 Church st., Newton (19)
Staehle, Richard H., 34 Lyons av., Newark (7)
Stage, Earl DeW., 11 James st., Morristown (14)
Stahl, Alfred, 55 Lincoln Park, Newark (7)
Stahl, Charles, 659 Sanford av., Newark (7)
Stalberg, Isaac Z., 1616 Pacific av., Atlantic City (1)
Stamps, George R., 300 E. Verona av., P'tsantville (1)
Stanton, Nathaniel B., 734 Park av., Plainfield (20)
Stark, Jacob, 645 Broadway, Paterson (16)
Statman, Arthur J., 17 Leslie st., Newark (7)
Staub, E. Milton, 531 E. Broad st., Westfield (20)
Steel, William A., Beesley's Point (5)
Steele, Stephen, 10 W. Gibbons st., Linden (20)
Steffens, Chas. T., 307 N. W'sh'gton av., Dunellen (12)
Stein, Emil, 607 Park av., Elizabeth (20)
Stein, George H., 406 Elmora av., Elizabeth (20)
Stein, Harry M., 227 W. Broadway, Paterson (16)
Stein, Isadore, 210 Elizabeth av., Elizabeth (20)
Stein, Jacob M., 68 Columbia ter., Weehawken (9)
Stein, Joseph M., 956 Newton av., Camden (4)
Stein, Louis A., 226 W. State st., Trenton (11)
Stein, Martin H., 60 Elmora av., Elizabeth (20)
Stein, William, 73 Livingston av., New Brunswick (12)
Steinberg, Benjamin L., 534 Main st., Singac (16)
Steinberg, Werner, 45 E. Henry st., Linden (20)
Steiner, Edwin, 31 Lincoln Park, Newark (7)
Stephenson, Daniel H., 213 Haddon av., Had'n'f'd (4)
Stephenson, Gordon A., 145 Summit av., Summit (20)
Stern, Samuel, 2815 Pacific av., Atlantic City (1)
Steuart, David F. R., 11 De Barry pl., Summit (20)
Stevenson, Alexand'r M., 7506 Vent'n'r av., Marg'te (1)
Stevenson, Geo. S., R.D. No. 1, Everett rd., Red B'k (13)
Stewart, Irving J., 529 King's H'way, Swedesboro (8)
Stewart, Robert G., 79 Midland av., Montclair (7)
Stewart, Sloan G., 16 N. Jackson av., Ventnor (1)
Stewart, Walter B., 8 N. Tallahassee av., Atl. City (1)

Stickles, Lloyd C., 49 Parkhurst st., Newark (7)
 Stiles, C. Campbell, 713 Park av., East Orange (7)
 Stillwell, Harry C., 51 W. Milton av., Rahway (20)
 Stinson, Richard, 641 E. 18th st., Paterson (16)
 Stockfish, Robert H., 3637 Boulevard, Jersey C'y (9)
 Stokes, Anthony T., 819 First st., Secaucus (9)
 Stokes, Earle B., 144 Harrison st., East Orange (7)
 Stokes, James S., 85 Park av., Paterson (16)
 Stokes, Joseph, 220 E. Main st., Moorestown (3)
 Stokes, S. Emlen, 129 Chester av., Moorestown (3)
 Stoltz, Raymond R., 23 Passaic av., Passaic (16)
 Stone, Arthur L., 2838 Berkeley st., Camden (4)
 Stone, Robert G., State Hospital, Trenton (11)
 Storaci, Frank S., 703 Hamilton av., Trenton (11)
 Stout, John P., 165 Jewett av., Jersey City (9)
 Stouter, Francis L., 29 17th av., Paterson (16)
 Strack, Vincent J., 1072 S. Orange av., Newark (7)
 Strahan, Frank G., 473 Broadway, Long Branch (13)
 Straub, Herbert H., 242 Springdale av., E. Orange (7)
 Straughn, Clinton C., 23 Monmouth st., Red Bank (13)
 Strauss, Arthur, 130 Pavilion av., Long Branch (13)
 Streen, Morris E., 908 Bergen st., Newark (7)
 Street, Daniel B., 27 Woodlawn av., Jersey City (9)
 Strelinger, Alexander, 650 N. Broad st., Elizabeth (20)
 Strom, Abraham, 410 W. 7th st., Plainfield (20)
 Stuart, James E., 552 E. Second st., Plainfield (20)
 Stuart, William C., 518 Hudson st., Hoboken (9)
 Sturchio, Edoardo, 104 Ferry st., Newark (7)
 Subin, Harry, 1616 Pacific av., Atlantic City (1)
 Sucoff, Moses C., 158 Hamilton av., Passaic (16)
 Suesserman, Henry, 389 Lyons av., Newark (7)
 Suffness, Gustave, 1087 E. Jersey st., Elizabeth (20)
 Sufrin, Emanuel, 119 N. 27th st., Camden (4)
 Sullivan, Chas. J., 57 Paterson st., New Brunswick (12)
 Sullivan, James A., 668 Jersey av., Jersey City (9)
 Sullivan, Wm. M., Jr., 43 Passaic av., Passaic (16)
 Sulouff, S. Henry, 662 Newark av., Jersey City (9)
 Summerill, Fred'k., 424 Terhune av., Passaic (16)
 Summerill, Garnett, 330 Cooper st., Camden (4)
 Summers, Alfred D., 180 Nassau st., Princeton (11)
 Summey, Thomas J., 201 E. Oak av., Moorestown (3)
 Surgent, George W., 168 Clifton av., Clifton (16)
 Surran, Carl A., 1616 Pacific av., Atlantic City (1)
 Sussman, Harold, 541 44th st., Union City (9)
 Suter, Harry F., 49 W. Main st., Penns Grove (17)
 Sutherland, Robt. C., 95 S. Broad st., Penns Grove (17)
 Sutherland, William W., 400 B'dway, Paterson (16)
 Sutnick, Theodore B., 1018 S. Broad st., Trenton (11)
 Sutton, Harold L., 777 High st., Newark (7)
 Sutton, Joseph G., Essex Co. Hosp., Cedar Grove (7)
 Sweeney, Wm. J., 68 Clifton ter., Weehawken (9)
 Swern, Nathan, 399 W. State st., Trenton (11)
 Swertfeger, Herb't W., 106 W. Broad st., Hopewell (11)
 Swieczicki, Martin E., 317 Clem'nts Br. rd., Bar'gt'n (4)
 Swiney, Juliana C., 325 Ave. C, Bayonne (9)
 Swiney, Merrill A., 325 Ave. C, Bayonne (9)
 Szerlip, Leopold, 31 Lincoln Park, Newark (7)
 Szold, Norman F., 701 Princeton av., Lakewood (15)
 Szu'ch, Nicholas, 159 Main st., South River (12)
 Szymanski, John J., 616 Main av., Passaic (16)

ASSOCIATE MEMBERS

Sackin, Stanley, 1009 Hamilton av., Trenton (11)
 Savel, Lewis E., 872 S. 16th st., Newark (7)
 Schretzmann, Rudolph C., 597 Riv'rside av., R'th'rf'd (2)
 Schwartz, Jacob, 8-04 Fair Lawn av., Fair Lawn (16)
 Schwartzberg, Seym'r H., Pier lane, R.F.D., Caldwell (7)
 Shechner, Isadore, 122 Broad st., Newark (7)
 Siegel, Jack G., 38 Johnson av., Newark (7)
 Smith, John A., 106 Main st., S. River (12)
 Smith, Joseph A., 133 Kearny av., Perth Amboy (12)
 Spicola, Louis A., 549 Anderson av., Wood Ridge (2)
 Stabile, John A., Grand av., West Trenton (11)
 Steel, John M., N. J. State Hospital, Trenton (11)

Strasser, Hans A., 569 Mt. Prospect av., Newark (7)
 Sullivan, William T., 35 DeWitt av., Belleville (7)

ACTIVE MEMBERS

Taber, Fred'k S., 49 Paterson st., New Brunswick (12)
 Taber, Leslie R., 266 Van Houten st., Paterson (16)
 Taff, Harry, 172 Roseville av., Newark (7)
 Taft, Herman L., 26 4th st., Weehawken (9)
 Talbot, Herbert S., 16 Eppert st., E. Orange (7)
 Talmage, Wm. G., Main st. & Hillside av., Succ'sna (14)
 Talty, John C., 935 Washington st., Hoboken (9)
 Tanner, Walter L., 12 De Hart st., Morristown (14)
 Tansey, William A., 98 Dover st., Newark (7)
 Taranto, Michael, 635 N. Wood av., Linden (20)
 Tarbell, Harold A., 13 Pennington st., Newark (7)
 Tataryan, Hovsep, 422 New York av., Union C'y (9)
 Tatem, Henry R., Jr., Pine st. & Atl. av., Audubon (4)
 Tator, Arthur E., 57 De Forest av., Summit (20)
 Taylor, G. Herbert, 144 Harrison st., E. Orange (7)
 Taylor, Malcolm C., N. J. State Hosp., Gr'y'st'ne P'k (14)
 Taylor, Raymond A., 58 Madison av., Lakewood (15)
 Taylor, Walter A., 450 Rutherford av., Trenton (11)
 Teeter, Charles E., 418 Orange st., Newark (7)
 Teller, D. Woolsey, Jr., 26 Maple av., Morristown (14)
 Tellman, Daniel H., 120 Lexington av., Passaic (16)
 Temes, Julius H., 293 Ege av., Jersey City (9)
 Temple, Arthur H., 164 Jefferson st., Passaic (16)
 Tenney, Albert S., 164 S. Harrison st., E. Orange (7)
 Tennis, Edgar M., 240 Engle st., Englewood (2)
 Terhune, Percy H., 358 Owen st., Radburn (16)
 Terrell, Edward E., 110 Alden st., Cranford (20)
 Terreri, D. Joseph, 30 High st., Morristown (14)
 Teskey, Stanley, 10 Anderson rd., Bernardsville (14)
 Tether, Russell K., Main st., Closter (2)
 Thalheimer, Edward J., 644 Plum st., Vineland (6)
 Thomas, Claude W., 28 East av., Woodstown (17)
 Thomas, Floyd A., 97 Main st., Flemington (10)
 Thomas, George N., 712 Wood st., Vineland (6)
 Thomas, Irene O., 275 Lafayette av., Hawthorne (16)
 Thomas, John H., 270 Lenox av., South Orange (7)
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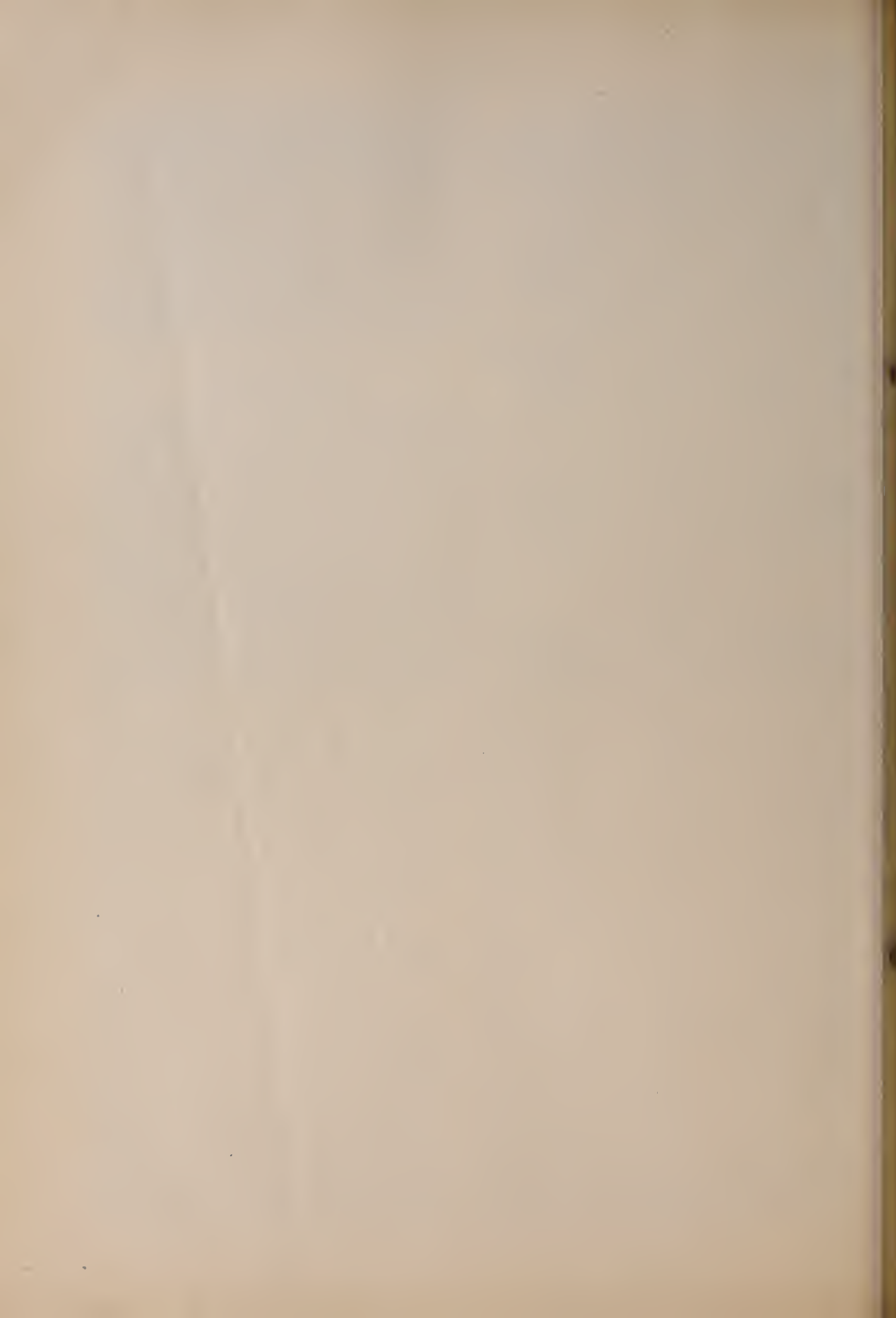
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G. W. CARNRICK CO.

Dependable Gland Products

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Newark, New Jersey

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

EXECUTIVE AND EDITORIAL OFFICES, 143 EAST STATE ST., TRENTON, N. J.
TELEPHONE 9330

OFFICERS

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Treasurer, ELIAS J. MARSHPaterson

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ALDRICH C. CROWE, *Secretary* (1941)Ocean City
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E. ZEH HAWKESNewark
WATSON B. MORRISSpringfield
THOMAS K. LEWISCamden
ALFRED STAHLNewark
ELIAS J. MARSHPaterson

HARRY R. NORTH (1939)Trenton
FREDERIC J. QUIGLEY (1939)Union City
THOMAS B. LEE (1939)Camden
WELLS P. EAGLETON (1940)Newark
ANDREW F. MCBRIDE (1940)Paterson
J. HOWARD HORNBERGER (1940)Roebling
HERBERT W. NAFFEY (1941)New Brunswick
SAMUEL ALEXANDER (1941)Park Ridge
WILLIAM F. COSTELLO (1941)Dover

COUNCILORS

First District (Union, Warren, Morris and Essex Counties).....CHRISTOPHER C. BELING, Newark (1939)
Second District (Sussex, Bergen, Hudson and Passaic Counties).....VINCENT P. BUTLER, Jersey City (1941)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties).....BARCLAY S. FUHRMANN, Flemington (1940)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties).....JAMES A. FISHER, Asbury Park (1939)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties).....CHESTER I. ULMER, Gibbstown (1941)

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Delegates

ANDREW F. MCBRIDE, PatersonTerm expires 1939
LUCIUS F. DONOHUE, Bayonne“ “ 1939
WELLS P. EAGLETON, Newark“ “ 1940
HILTON S. READ, Atlantic City“ “ 1940

Alternate Delegates

SPENCER T. SNEDECOR, HackensackTerm expires 1939
RALPH K. HOLLINSHED, Westville“ “ 1939
ELMER P. WEIGEL, Plainfield“ “ 1940
LANCELOT ELY, Somerville“ “ 1940

OFFICERS OF SCIENTIFIC SECTIONS

Eye, Ear, Nose and Throat

NORMAN W. BURRITT, *Chairman*Summit
A. RUSSELL SHERMAN, *Secretary*Newark

Pediatrics

IRVING OKIN, *Chairman*Passaic
WARREN RIPLEY, *Secretary*Montclair

Medicine

JOHN W. GRAY, *Chairman*Newark
THOMAS KAIN, *Secretary*Camden

Obstetrics and Gynecology

WALTER B. MOUNT, *Chairman*Montclair
J. CARLISLE BROWN, *Secretary*Atlantic City

Surgery

ROBERT S. GAMON, *Chairman*Camden
LYNDON A. PEER, *Secretary*Newark

Radiology

MILTON FRIEDMAN, *Chairman*Newark
W. JAMES MARQUIS, *Secretary*Newark

Gastro-Enterology

MANFRED KRAEMER, *Chairman*Newark
HYMAN I. GOLDSTEIN, *Secretary*Camden

CO-OPERATING ORGANIZATIONS

The Department of Health of the State of New Jersey

J. LYNN MAHAFFEY, M.D., *Director of Health*
State House, Trenton, N. J.
Tel. 2-2131, Ext. 541

State Crippled Children's Commission

J. G. BUCH, *Chairman and Director*
732 Broad Street Bank Building, Trenton
Tel. 2-2131, Ext. 785

State Board of Children's Guardians

JOSEPH E. ALLOWAY, *Executive Director*
163 West Hanover Street, Trenton
Tel. 2-2131, Ext. 308

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EARL S. HALLINGER, M.D., *Secretary*
Trenton Trust Bldg., 28 W. State St., Trenton, N. J.
Room 1101, Tel. Trenton 2-2131, Ext. 272

New Jersey Health Officers' Association

MR. WILLIAM C. BLAKE, *Secretary*
Thomson Hall, Princeton, N. J.
Tel. Princeton 1005

New Jersey Health and Sanitary Association

JOHN HALL, *Executive Secretary*
Frechhold, N. J.
Tel. 65-W

Department of Institutions and Agencies

WILLIAM J. ELLIS, Ph. D., *Commissioner*
State House Office Building, Trenton
Tel. 2-2131, Ext. 737

New Jersey State Nurses' Association

MISS MARGARET ASHMUN, R.N., *President*
Orange Memorial Hospital, Orange, New Jersey
Tel. Orange 5-1100

New Jersey Hospital Association

FRED HEFFINGER, *Executive Secretary*
Mercer Hospital, Trenton
Tel. 8241

State Board of Pharmacy

ROBERT P. FISCHELIS, Phar. D., *Secretary*
Trenton Trust Building, Trenton
Tel. 2-2131, Ext. 546

Department of Motor Vehicles

ARTHUR W. MAGEE, *Commissioner*
State House Office Building, Trenton
Tel. 2-2131, Ext. 208

THE MEDICAL SOCIETY OF NEW JERSEY

COMMITTEES,—THEIR MEMBERS AND DATES OF MEETINGS,—FOR THE YEAR BEGINNING MAY 19, 1938

WILLIAM J. CARRINGTON, Atlantic City, President and Ex-Officio Member of Each
Committee —By-Laws, Chapt. VI, Sect. 1

Adult Health Supervision

HERSCHEL STRATTON MURPHY, *Chairman* Roselle
WILLIAM HENRY VARNEY, *Vice-Chairman* Wasington
EDWIN GRAFING DEWIS Interlaken
ROBERT MARTIN GRIER Pleasantville
EDWARD CAFFRON KLEIN Newark
AUGUSTUS S. KNIGHT Far Hills
ADOLPH TOWBIN Lakewood
WATSON BUDLONG MORRIS, *Consultant* Springfield

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Annual Meeting

CHARLES BUTCHER KAIGHN, *Chairman* Atlantic City
CLARENCE LADELLE ANDREWS, *Chairman*, Sub-Com. on
Scientific Program Atlantic City
ASHER YAGUDA, *Chairman*, Sub-Com. on Scientific Ex-
hibits Newark
THOMAS McGRATH BRENNOCK Jersey City
JOHN CLIFFORD CLARK Asbury Park
WILLIAM JOHN CARRINGTON, *Consultant* Atlantic City

Meetings

Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Auxiliary Medical Service

WILLIAM WALLACE MAVER, *Chairman* Jersey City
SAMUEL BARBASH, *Vice-Chairman* Atlantic City
ARTURO RAYMOND CASILLI Elizabeth
EUGENE GARFIELD HERBENER Lakewood
SIGURD WALTER JOHNSEN Passaic
JEROME HOWARD SAMUEL Newark
WALTER ALBERT TAYLOR Trenton
ALFRED STAHL, *Consultant* Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Cancer Control

WILLIAM GETTIER HERRMAN, *Chairman* Asbury Park
HENRY BOYLAN ORTON, *Vice-Chairman* Newark
HAROLD STERN DAVIDSON Atlantic City
ELLWOOD EMERSON DOWNS Woodbury
JOHN BUTLER FAISON Jersey City
OTTO RUDOLPH HOLTERS Asbury Park
JOSEPH HENRY KLER New Brunswick
AUGUSTUS S. KNIGHT Far Hills
CHARLES B. WOODMAN Morristown
THOMAS BENJAMIN LEE, *Consultant* Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Child Health

STANLEY NICHOLS, *Chairman* Long Branch
WALTER BLAIR STEWART, *Vice-Chairman* Atlantic City
ARTHUR FOWLER ACKERMAN Summit
CHESTER BROWN Arlington
ERNEST GARFIELD HUMMEL Camden
IRVING OKIN Passaic
LOUIS CHARLES ROSENBERG Newark
ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Conservation of Vision

ELBERT STETSON SHERMAN, *Chairman* Newark
CHARLES H. SCHLICHTER Elizabeth
ELIAS J. MARSH Paterson
WALLACE PYLE Jersey City
JOSEPH HENRY KLER New Brunswick

Constitution and By-Laws

JAMES FRANCIS NORTON, *Chairman* Jersey City
DAVID KRAKER, *Vice-Chairman* Newark
HERBERT WILLIAM NAFAY New Brunswick
GEORGE N. J. SOMMER Trenton
DAVID H. BARTINE ULMER Moorestown
FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.

Contract Practice

REUBEN LORE SHARP, *Chairman* Camden
L. SAMUEL SICA, *Vice-Chairman* Trenton
FRANK WILLIAM ASH Paterson
JOHN GEORGE DECKER Hasbrouck Heights
HENRY HAYWOOD New Brunswick
HARVEY THEODORE HEROLD Newark
EDWARD FREDERICK KLEIN Perth Amboy
JENNINGS HOWARD HORNBERGER, *Consultant* Roebling
ANDREW C. RUOFF Union City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Crippled Children

BABCLAY WELLINGTON MOFFAT, *Chairman* Red Bank
ELMER PETER WEIGEL, *Vice-Chairman* Plainfield
OSWALD RUDOLPH CARLANDER Camden
FREDERICK GEORGE DILGER Hackensack
WILLIAM GREENFIELD Hackensack
EMANUEL HARRISON NICKMAN Atlantic City
TOUPICK NICOLA Montclair
HERBERT WILLIAM NAFAY, *Consultant* New Brunswick

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Finance and Budget

HARRY ROSS NORTH, *Chairman* (1939)Trenton
HERSCHEL PETTIT (1942)Ocean City
WELLS PHILLIPS EAGLETON (1943)Newark
ANDREW FRANCIS MCBRIDE (1941)Paterson
DAVID B. ALLMAN (1944)Atlantic City
HENRY SPENCE (1940)Jersey City
ELIAS JOSEPH MARSH, *Ex-Officio*Paterson

Honorary Membership

LANCELOT ELY, *Chairman*Somerville
*EPHRAIM ROLAND MULFORDBurlington
FREDERIC JAMES QUIGLEYUnion City
No meetings, work carried on by correspondence.

Hospital Relationships

SPENCER TREADWELL SNEDECOR, *Chairman*Hackensack
WILLIAM H. A. WARNER, *Vice-Chairman*East Orange
HENRY BRISTOL DECKERCamden
FLORENTINE MILTON HOFFMANNew Brunswick
CHARLES HYMANAtlantic City
ELTON WALLACE LANCERahway
GEORGE O'HANLONJersey City
THOMAS KRAPPEN LEWIS, *Consultant*Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Industrial Injuries and Occupational Diseases

J. IRVING FORT, *Chairman*Newark
LESLIE EDWIN MYATT, *Vice-Chairman*Bridgeton
CHARLES LITWINTeaneck
TRAUGOTT JOHN SCHUCKHoboken
JAMES HERBERT SPENCER, JR.Franklin
WILLIAM FRANCIS COSTELLO, *Consultant*Dover
HENRY HOWARD KESSLER, *Technical Adviser*, representing
Commissioner J. J. Toohey, N. J. Dept. of Labor.....Newark
ROY GRIFFITH, *Technical Adviser*, representing the Manu-
facturers' Association of New JerseyGlen Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Legislation

BERTHOLD STEINBACH POLLAK, *Chairman*Secaucus
CHARLES HENRY MITCHELL, *Vice-Chairman*Trenton
WENDALL JONES BURKETTPitman
HERBERT ROY VAN NISSNewark
WILLIAM CRANE WILENTZPerth Amboy
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
Others at call of Chairman

Maternal Welfare

ARTHUR WALTER BINGHAM, *Chairman*East Orange
JOHN CARLISLE BROWN, *Vice-Chairman*Atlantic City
SAMUEL ALLISON COSGROVEJersey City
GEORGE BURTON GERMANCamden
CARL HALLER ILLNewark
JULIUS LEVYNewark
ROBERT ABBE MACKENZIEAsbury Park
WALTER BARCLAY MOUNTMontclair
JAMES HARRIS UNDERWOODWoodbury
HARRISON BETTS WILSONHackensack
THOMAS BENJAMIN LEE, *Consultant*Camden

Meetings

Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
January, 1939, Joint Meeting with County Ma-
ternal Committees and Field Physicians; date,
hour, and place to be selected by Chairman,
Dr. Bingham.

* Deceased.

Medical Care of Indigent and Low-Wage Group

GEORGE WASHINGTON FITHIAN, *Chairman*Perth Amboy
DAVID WRIGHT GREEN, *Vice-Chairman*Salem
FRANK L. FIELDFar Hills
DANIEL LEO HAGGERTYTrenton
WARREN DAVID ROBBINSCape May
BYRON GRANT SHERMANMorristown
EDWARD MATHIAS ZEH HAWKES, *Consultant*Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Medical Defense and Insurance

CHRISTOPHER CHARLES BELING, *Chairman*Newark
JOSEPH WALLACE HURFF, *Vice-Chairman*Newark
JOHN CHARLES MCCOYPaterson
GEORGE THOMAS TRACYBeverly
WILLIAM CARTER WESCOTTAtlantic City
WELLS PHILLIPS EAGLETON, *Consultant*Newark

Meetings

Atlantic City...May 19, 1938.....4 p. m.
Interim meetings at the call of Chairman
Trenton.....Apr. 16, 1939.....4 p. m.

Medical Practice

DAVID BACHARACH ALLMAN, *Chairman*Atlantic City
SPENCER TREADWELL SNEDECOR, *Vice-Chairman*Hackensack
HARRY NOAH COMANDONewark
GEORGE WASHINGTON FITHIANPerth Amboy
JACOB IRVING FORTNewark
WILLIAM WALLACE MAVERJersey City
RUBEN LORE SHARPCamden
CHESTER ISAAC ULMERGibbstown
ANTHONY CHARLES ZEHNDERNewark
THOMAS KRAPPEN LEWIS, *Consultant*Camden

Meetings

Atlantic City...May 19, 1938.....4 p. m.
Trenton.....Apr. 16, 1939.....4 p. m.
For meeting of Advisory Committees see their
schedules

Mental Hygiene

JAMES STUART PLANT, *Chairman*Newark
MARCUS ALBERT CURRY, *Vice-Chairman*Greystone Park
WILLIAM COLE DAVISAtlantic City
BARCLAY STOKES FUHRMANNFlemington
ALLEN GILBERT IRELANDTrenton
EDWARD SHEAFE KRANSPlainfield
CLARENCE MORTON TRIFFEAsbury Park
HERBERT WILLIAM NAFEE, *Consultant*New Brunswick
AMBROSE DOWD, *Technical Adviser*, representing Commis-
sioner Ellis, N. J. Department of Institutions and
AgenciesNewark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.
One or two other meetings at call of Chairman

Nursing and Nursing Education

ANTHONY CHARLES ZEHNDER, *Chairman*Newark
GEORGE MILTON KNOWLES, *Vice-Chairman*Hackensack
HORACE WESLEY JACKCamden
VICTOR KNAFFAsbury Park
FRANK LESLIE PERRYWoodstown
HARRY SUBINAtlantic City
THOMAS J. FRANCIS WALSHElizabeth
WELLS PHILLIPS EAGLETON, *Consultant*Newark

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Pharmaceutical Problems

CHESTER ISAAC ULMER, *Chairman*Gibbstown
REEVE LESLIE BALLINGER, *Vice-Chairman*Arlington
JACOB JOHN MANNPerth Amboy
MERWIN LESTER HUMMELMerchantville
CHARLES JOSEPH MURNPaterson
DANIEL WOOLSEY TELLER, JR.Morristown
RALPH KING HOLLINSHED, *Consultant*Westville

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Pneumonia Control

ROBERT ANTHONY KILDUFFE, *Chairman*Atlantic City
THOMAS MICHAEL KAINCamden
HENRY PAUL DENGLESpringfield
*MARSHALL FLOWER LUMMISPitman
FREDERICK THOMAS VOSBURGHPassaic
RALPH KING HOLLINSHED, *Consultant*Westville
WILLIAM MACDONALD, *Technical Adviser*, representing
Dr. J. Lynn Mahaffey, Director N. J. Department of
HealthTrenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Post-Graduate Education

DAVID FULLER BENTLEY, *Chairman*Haddonfield
STUART ZEH HAWKES, *Vice-Chairman*Newark
ALBERT WILLIAM PIGOTTSkillman
ERNEST FRANCIS PURCELLTrenton
HAMMELL PIERCE SHIPPSDelanco
SLOAN GRIFFIN STEWARTAtlantic City
CLARENCE WILTON WAYSea Isle City
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.

Public Health

STANLEY NICHOLS, *Chairman*Long Branch
FREDERIC WILLIAM LATHROP, *Vice-Chairman*Plainfield
FRANK A. BIENIrvington
ARTHUR WALTER BINGHAMEast Orange
CHARLES BYRON BLAISDELLLong Branch
JACOB IRVING FORTNewark
ERNEST GARFIELD HUMMELCamden
ALLEN GILBERT IRELANDTrenton
ABRAHAM EZRA JAFFINJersey City
ROBERT ANTHONY KILDUFFEAtlantic City
*ISAAC WARNER KNIGHTPitman
JULIUS LEVYNewark
BARCLAY WELLINGTON MOFFATAsbury Park
HERSCHEL STRATTON MURPHYRoselle
HENRY BOYLAN ORTONNewark
JAMES STUART PLANTNewark
ELBERT STETSON SHERMANNewark
*THEODOR TEIMERNewark
EDWARD MATHIAS ZEH HAWKES, *Consultant*Newark

Technical Advisers

ELLEN POTTER and EMIL FRANKEL, representing Wm. G. Ellis,
N. J. Dept. Institutions and Agencies.
HENRY HOWARD KESSLER, representing J. J. Toohey, N. J.
Dept. of Labor.
WILLIAM MACDONALD, representing Director Mahaffey, N. J.
Dept. of Health.
HOWARD DARE WHITE, representing Director Elliott, N. J.
Dept. of Public Instruction.

Meetings

Long Branch....July 10, 1938.....3 p. m.
Newark.....Sept. 7, 1938.....3 p. m.
Newark.....Oct. 5, 1938.....3 p. m.
Newark.....Nov. 2, 1938.....3 p. m.
Newark.....Dec. 7, 1938.....3 p. m.
Newark.....Jan. 4, 1939.....3 p. m.
Newark.....Feb. 1, 1939.....3 p. m.
Newark.....Mar. 1, 1939.....3 p. m.
Newark.....Apr. 5, 1939.....3 p. m.
Newark.....May 3, 1939.....3 p. m.

*Deceased.

Public Relations

JOSEPH HENRY KLER, *Chairman*New Brunswick
JOSEPH BERKELEY GORDON, *Vice-Chairman*Marlboro
GEORGE BARTON BARLOWEnglewood
EDGAR PARMELE CARDWELLNewark
HOMER ISAAC SILVERSVentnor
JACOB ALLEN YAGERPaterson
ELIAS JOSEPH MARSH, *Consultant*Paterson

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Publication

HENRY C. BARKHORN, *Chairman* (1939)Newark
EDWARD J. ILL (1940)Newark
JAMES LAWRENCE EVANS (1941)North Bergen
WILLIAM JOHN CARRINGTON, *Ex-Officio*Atlantic City
ALFRED STAHL, *Ex-Officio*Newark
FRANK OVERTON, *Editor*Trenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Newark.....July 27, 1938.....4:30 p. m.
Newark.....Aug. 31, 1938.....4:30 p. m.
Newark.....Sept. 28, 1938.....4:30 p. m.
Newark.....Oct. 26, 1938.....4:30 p. m.
Newark.....Nov. 23, 1938.....4:30 p. m.
Newark.....Dec. 28, 1938.....4:30 p. m.
Newark.....Jan. 25, 1939.....4:30 p. m.
Newark.....Feb. 22, 1939.....4:30 p. m.
Newark.....Mar. 29, 1939.....4:30 p. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Exhibits

ASHER YAGUDA, *Chairman*Newark
JAMES GORDON BOYES, *Vice-Chairman*Plainfield
NICHOLAS MARK ALTERJersey City
WILLIAM WOLF HERSOHNAtlantic City
LUTHER AGUSTUS MARKLEYTeaneck
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Program

CLARENCE LADELLE ANDREWS, *Chairman*Atlantic City
ROBERT SPEER GAMON, *Vice-Chairman*Camden
LOUIS CHARLES LANGEWeehawken
HARRISON STANFORD MARTLANDNewark
PAUL BRYSON REISINGERTrenton
WILLIAM JOHN CARRINGTON, *Consultant*Atlantic City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Study of Sterilization

CHARLES WRIGHT MACMILLAN, *Chairman*Passaic
SAMUEL EMLIN STOKES, *Vice-Chairman*Moorestown
WALTER JOHN FARRTeaneck
THEODORE RUSSELL ROBIEEast Orange
*ALFRED FREDERICK SFERRABound Brook
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Traffic Accidents

ELBERT STETSON SHERMAN, *Chairman*Newark
MILLARD FREEMAN SEWALL, *Vice-Chairman*Bridgeton
THOMAS SIMON PADDOCK FITCHPlainfield
CHRISTIAN PETER SEGARDLeonia
GEORGE JOHN YOUNGMorristown
JESSE LYNN MAHAFFEYHaddonfield
WATSON BUDLONG MORRIS, *Consultant*Springfield
ARNOLD VEY, *Technical Adviser*, representing A. W. Magee, Commissioner of Motor Vehicles of N. J.Trenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Tuberculosis

ABRAHAM EZRA JAFFIN, *Chairman*Jersey City
SAMUEL BUDD ENGLISH, *Vice-Chairman*Glen Gardner
NORMAN WYVELL BURRITTSummit
LEO BERTHIER DRAKEFranklin
CLYDE M. FISHPleasantville
MARCUS WARD NEWCOMBBrowns Mills
HAROLD SIMON HATCHMorristown
JOHN EDMUNDS RANNELLSScotch Plains
HARRY BURTON WALKERVineland
FREDERIC JAMES QUIGLEY, *Consultant*Union City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Venereal Disease Control

CHARLES BYRON BLAISDELL, *Chairman*Long Branch
MARSHALL DAVIS HOGANBoonton
BAXTER ALFONSO LIVENGODSwedesboro
STANLEY MARTIN MCGEEHANAtlantic City
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WILLIAM FRANCIS COSTELLO, *Consultant*Dover
ARTHUR JAY CASSELMAN, *Technical Adviser*, representing Dr. Jesse Lynn Mahaffey, Director of N. J. Dept. of HealthCamden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Voluntary Health Insurance

ELTON WALLACE LANCE, *Chairman*Rahway
EDWARD W. SPRAGUENewark
JAMES F. NORTONJersey City
FRANCIS HARRISON TODDPaterson
WILLIAM G. HERRMANAsbury Park
J. ALLEN YAGERPaterson
LESLIE EDWIN MYATTBridgeton
NORMAN NES FORNEYMilltown
AUGUSTUS S. KNIGHTFar Hills
HALVOR L. HARLEYAtlantic City
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HILTON SHREVE READ, *Chairman*Ventnor
WILLIAM JOHN CARRINGTON, *Ex-Officio*Atlantic City
ALFRED STAHL, *Ex-Officio*Newark
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GEORGE BARTON BARLOWEnglewood
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CHARLES BYRON BLAISDELLLong Branch
WENDALL JONES BURKETTPitman
NORMAN WYVELL BURRITTSummit
EDGAR PARMELE CARDWELLNewark
HARRY NOAH COMANDONewark
MARCUS ALBERT CURRYGreystone Park
WALTER JOHN FARRTeaneck
FRANK L. FIELDFar Hills
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JACOB IRVING FORTNewark
BARCLAY STOKES FUHRMANNFlemington
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DAVID WRIGHT GREENSalem
DANIEL LEO HAGGERTYTrenton
DONALD OSBORN HAMBLINBound Brook
HENRY HAYWOODNew Brunswick
EUGENE GARFIELD HERBENERLakewood
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ERNEST GARFIELD HUMMELCamden
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ABRAHAM EZRA JAFFINJersey City
SIGURD WALTER JOHNSENPassaic
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*ISAAC WARNER KNIGHTPitman
FREDERIC WILLIAM LATIROPPlainfield
JULIUS LEVYNewark
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WILLIAM WALLACE MAVERJersey City
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BARCLAY WELLINGTON MOFFATRed Bank
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STANLEY HETFIELD NICHOLSLong Branch
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Meetings

Trenton.....June 5, 1938.....1 p. m.
Trenton.....Oct. 2, 1938.....1 p. m.
Trenton.....Dec. 4, 1938.....1 p. m.
Trenton.....Feb. 19, 1939.....1 p. m.
Trenton.....Apr. 16, 1939.....1 p. m.

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Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

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ROY GRIFFITH, *Technical Adviser*, representing the Manufacturers' Association of N. J.Glen Ridge

Meetings

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Trenton.....Apr. 16, 1939.....11 a. m.

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MONMOUTH	William Heatley	Red Bank	80
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OCEAN	George W. Gaumer	422 First St., Lakewood	81
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GELATINE (U. S. P.)**



CASE I—FEMALE, 74

Uncomplicated gastric ulcer first demonstrated by Roentgen rays in 1934. Diet and alkalies afforded little relief. Accompanied by loss of weight. Repeated X-ray studies in 1936 and 1937 showed no improvement. She was placed on a diet-gelatine regime in November, 1937. Relief immediate. Gained weight. Roentgen studies in April, 1938 showed no demonstrable ulcer.

NOTE:

The gelatine used in this study was plain Knox Gelatine (U.S.P) which assays 85% protein and which should not be confused either with inferior grades of gelatine or with sugar-laden dessert powders, for these latter products will not achieve the desired effects. When you desire pure U.S.P. Gelatine, be sure to specify KNOX. Your hospital can get it on order.

CLINICAL research has recently demonstrated the effectiveness of utilizing plain Knox Gelatine (U.S.P.) in treatment of peptic ulcer. In a group of 40 patients studied, 36 (or 90%) were symptomatically improved; 28 of these (or 70%) experienced *immediate relief of all symptoms*. Other than dietary regulation which included frequent feedings of plain Knox Gelatine no medication was given except an occasional cathartic.

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This regime thus eliminates the "alkalosis hazard" attendant upon continued alkali therapy. In discussing the mode of action by which gelatine brings peptic ulcer relief, Windwer and Matzner* speak of the acid-binding properties by which proteins can neutralize acids, and they state that the frequent gelatine feedings "apparently caused more prolonged neutralization of the gastric juice."

PEPTIC ULCER FORMULA

Empty one envelope Knox Gelatine in a glass three-quarters filled with cold water or milk. Let gelatine settle to the bottom of the glass, then stir briskly and drink immediately. Take hourly between feedings for seven doses a day.

*Windwer and Matzner, *Am. Jl. Dig. Dis.*, 5:743, 1939.

WRITE DEPT. 430



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Pontocaine hydrochloride is effective in relatively low concentrations. Solutions ranging from 0.5 per cent to 2 per cent are generally employed, depending upon the required degree of anesthesia. As no material effect is produced on the blood vessels of the mucous membranes, any desired degree of vasoconstriction can be easily obtained by the addition of Suprarenin (1:1000).

HOW SUPPLIED: For surface anesthesia in ophthalmology, Pontocaine hydrochloride 0.5 per cent solution in bottles of ½ oz. and 2 oz. Chlorobutanol (0.4 per cent) is added to maintain sterility.

For surface anesthesia in rhinolaryngology, Pontocaine hydrochloride 2 per cent solution in bottles of 1 oz. and 4 oz. Chlorobutanol (0.4 per cent) is added to maintain sterility. This solution is colored with methylene blue to prevent its accidental use for injection.

For surface anesthesia in ophthalmology and rhinolaryngology, tablets of 0.1 Gm., tubes of 15 and bottles of 100. (Tablets to be dissolved in boiling water.)

*Suprarenin (synthetic epinephrine, Winthrop)

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Clinical study has shown DIAL with Urethane to be useful in obstetrical analgesia. (Van Del., D. T., Jl. Missouri State Med. Assoc., March, 1938.)

LITERATURE UPON REQUEST

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REPORT OF THE COUNCIL ON PHARMACY AND CHEMISTRY (Announcement of Acceptance)—*J. A. M. A.*, 111:27, July 2, 1938.

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Answers to Physicians' Questions

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A. Dextrin	50.0%
Maltose	23.2%
Dextrose	16.0%
Sucrose	6.0%
Invert sugar	4.0%
Minerals	0.8%
(Dry Basis)	

2. Q. What are the properties of Karo?

A. *Uniform composition.*
Well tolerated.
Readily digested.
Non-fermentable.
Chemically dependable.
Bacteriologically safe.
Hypo-allergenic.
Economical.

3. Q. What are the Karo equivalents?

A. 1 oz. vol.	40 grams
	120 cals.
1 oz. wt.	28 grams
	90 cals.
1 teaspoon	15 cals.
1 tablespoon	60 cals.

Starch is extracted from thoroughly cleaned Indian corn. The colloidal solution is acidified and treated with superheated steam up to a pressure of thirty-five pounds per square inch to effect hydrolysis. The pressure is then released, the product neutralized, filtered, concentrated and refined.

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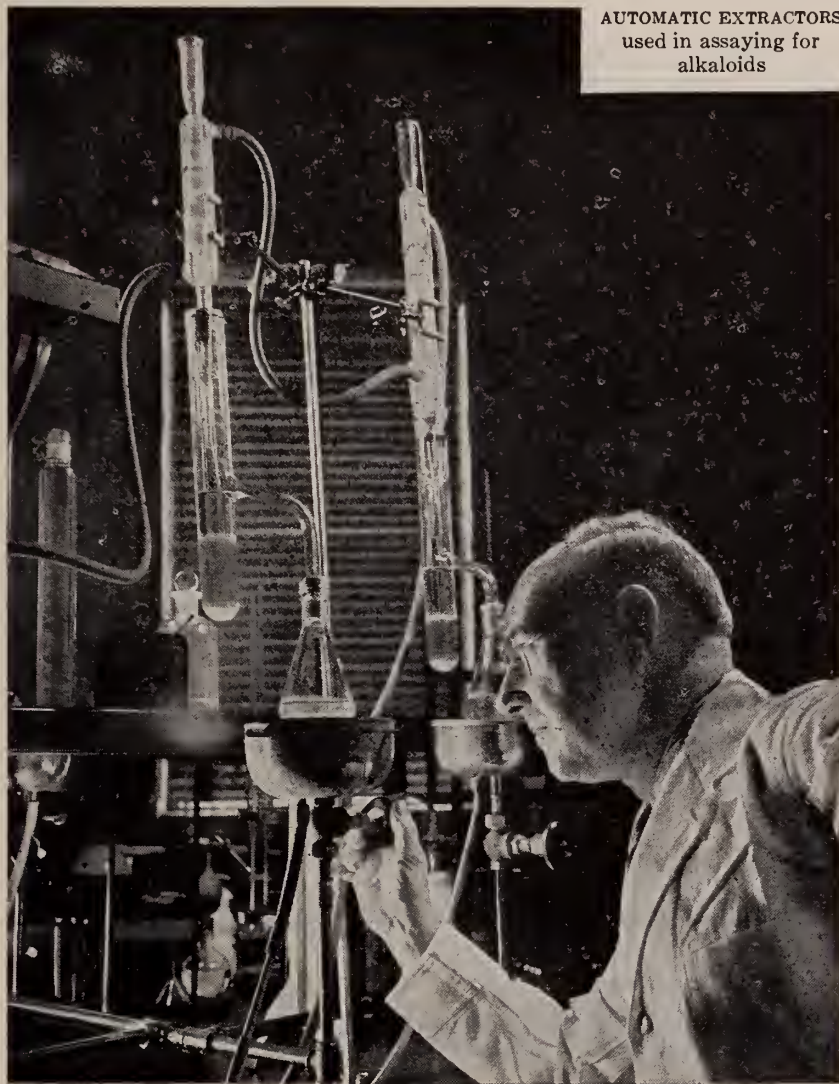
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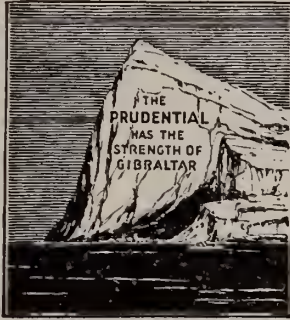
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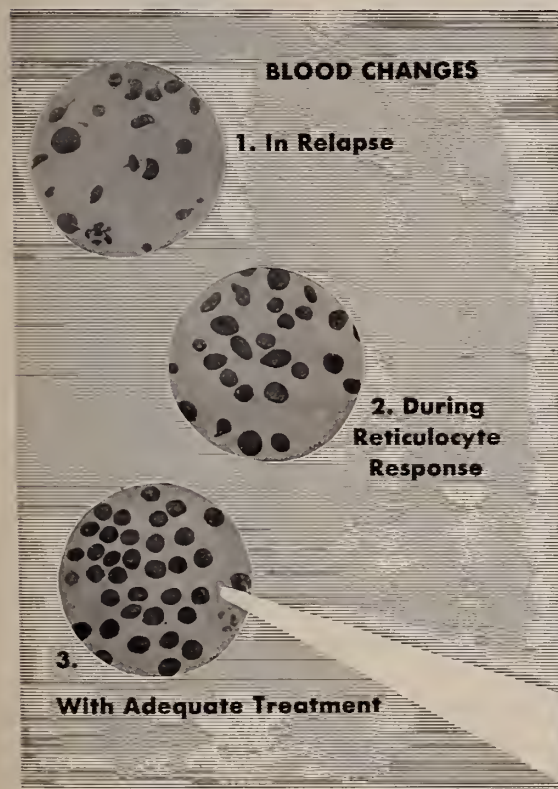
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4	53-104	3.9	5.26
15	105-156	3.2	5.18
2	157-208	3.9	5.21

Reprinted from "The Use of Concentrated Liver Extracts in Pernicious Anemia" by William P. Murphy, M.D. and Isabel Howard, Jo. A.M.A., January 14, 1939, Vol. 112, pp. 106-110.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



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EDITORIAL

THE ANNUAL MEETING AN INVITATION

Atlantic City, N. J., May 1, 1939.

Dear Member:

President Carrington and his associated officers and committeemen cordially invite you to participate in the 173rd Annual Meeting of The Medical Society of New Jersey on June 6-8, 1939, in Haddon Hall, Atlantic City.

CHARLES B. KAIGHN, *Chairman*
CLARENCE L. ANDREWS
ASHER YAGUDA
THOMAS MCG. BRENNOCK
JOHN C. CLARK
WILLIAM J. CARRINGTON, *Consultant*

A REMINDER

One does not usually receive an invitation to his own party. This is such an invitation. The Annual Meeting is made possible by your interest and financial support. It is planned for your information and enjoyment.

The scientific programs this year are better planned, and more informative than ever before.

The scientific exhibits are worthy of a National Convention.

The commercial exhibits are interesting and informative.

The historical exhibits are inspiring.

The time spent at this meeting will pay you dividends in knowledge, recreation, and satisfaction.

Your attendance will help the Society to present a "United medical front" to the social and political agitators.

Plan now to be with us in Atlantic City, June 6-8, 1939.

CHARLES B. KAIGHN, *Chairman*.

May 19, 1938—OFFICERS—THE MEDICAL SOCIETY OF NEW JERSEY—June 8, 1939

E. Z. HAWKES
President-ElectWM. J. CARRINGTON
PRESIDENTT. K. LEWIS
Second Vice-PresidentALFRED STAHL
SecretaryW. B. MORRIS
First Vice-PresidentE. J. MARSH
Treasurer

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THE PRESIDENT'S PAGE

NUMBER TWELVE

THE PRESIDENT'S ANNUAL REPORT

By WILLIAM JOHN CARRINGTON, M.D., Atlantic City, N. J.

Portrait, Page 256

Last May The Medical Society of New Jersey dedicated itself to three objectives, as follows*:

1. *To make available to every man, woman and child in New Jersey adequate personal and sympathetic medical care, preventive and curative, at the lowest cost compatible with efficient service.*

2. *To preserve for all the people of New Jersey, regardless of income, the free choice of physicians among those licensed by the State to engage in the healing art.*

3. *To advance medical science, elevate professional standards, foster friendly relations between doctors, and promote mutual understanding between the doctors and the public.*

These objectives were not new, but had long given unexpressed decree and direction to this Society. In many parts of the world, particularly Europe, there is a retrogressive trend from democracy to autocracy. Under totalitarianism freedom is lost, and the welfare of the individual matters only as it affects the welfare of the State. Swirls and eddies of autocracy reached the shores of America and threatened the stability of free enterprise, medicine included. The times, therefore, demand clear thinking and wise planning.

ADMINISTRATIVE POLICIES

Last May The Medical Society of New Jersey designed a broad, twelve-point program, with a number of new administrative policies, to meet the challenge of events.* Many feared that the proposals were too inclusive and ambitious, and that they would soon be ignored or repudiated like the planks of a political party platform. Let us compare the program as planned with actual accomplishments.

1. SURVEY OF MEDICAL SERVICES

A State-wide survey was planned by medical men, county by county, of the supply of doctors, dentists, druggists, nurses, hospitals, and all other institutions, departments and agencies, private and public, concerned with the health of our people. Of the appropriation of

\$1000 for the New Jersey survey, only \$600 was needed for its completion. It was a part of a nation-wide study by the American Medical Association.

As the result of a previous perfunctory survey by a lay group, the statement was made and repeated from coast to coast that one-third of the people of the United States are without adequate medical care; and therefore the Government must take over the practice of medicine. The New Jersey survey showed that facilities for adequate care are available in this State for all of the people whether rich or poor. Eighteen per cent of the public do not want medical service of any kind, but prefer Christian Science, faith healing, fads, cults, and the like.

Another fragmentary lay survey seemed to show that 17,000,000 Americans are more than thirty miles removed from general hospitals and, therefore, the Government must launch into an expensive hospital-building program. Our survey showed that in New Jersey, with a population of 4,041,334 (Census of 1930), no man, woman, or child is more than thirty miles from a general hospital. Moreover, it showed that less than 70 per cent of these hospital beds are occupied. From our survey, one must not infer that the distribution of medical service in New Jersey is perfect, or that every section of the State is amply supplied with hospital beds; but our survey does prove that no great emergency exists to justify the Government in taking over the practice of medicine, or in plunging into bankruptcy by an extensive and expensive hospital-building program. The New Jersey survey, however, does much more than merely refute the statement that a great emergency exists. It now serves, and will continue to serve, as an intelligent factual basis for improvement.

On July 7, 1938, newspapers throughout the State carried this appeal: "Any individual, family, or group in New Jersey that for any reason has not obtained, or cannot obtain, adequate medical care in time of need is urged to communicate with The Medical Society of New Jersey, 143 East State Street, Trenton, New Jersey. Steps will be taken immediately

*Jour. Med. Soc. of N. J., June, 1938, p. 374.

by the Society in coöperation with its county medical societies to assure adequate medical care for those in need of it."

On July 23, 1938, this appeal was repeated by the officers of the Society over eleven radio stations in the State. As a result of these repeated requests, 170 inquiries were received. All were referred to the county societies where the persons lived, and upon investigation, it was found that adequate medical care was available for all but one. Although facilities are available, not everyone knows where to find them. The single exception was a woman who wanted a criminal abortion.

Those who would substitute government-controlled medicine for private practice, view with alarm what they term the present great emergency. They say that the medical profession is reactionary because we would have reason rule. Doctors are not opposed to progress. No profession has made greater scientific progress in the past fifty years. But let us not mistake *change* for *progress*. Let us subject neither doctors nor the sick to the control of politicians. Let us take a good look before we leap.

A National Health Conference was held in Washington last July. Practicing physicians, who ought to possess more practical knowledge of the nation's health than any other group, were not asked even to help formulate the recommendations of the Conference. As a result, we believe the program presented was impractical and extravagant. The theorists who formulated it predicated it upon incorrect data, and assumed that the expenditure of vast astronomical sums of money would solve all the health problems of the nation.

In sharp and refreshing contrast to this approach was the New Jersey procedure. Governor Moore called a State Health and Welfare Conference. Practicing physicians were consulted at every turn. The Medical Society of New Jersey gathered factual data, and was able to render the Governor and the State promptly experience and service in constructing a practical and economic State health program.

2. COST OF ILLNESS

The second administrative policy of The Medical Society of New Jersey as outlined last May was to lower the cost of illness by the application of sound economic principles in the distribution of medical care by protecting the public against the incompetent and mercenary within the profession, the ignorant cult practitioner, and fraudulent patent medicines; and to lessen the unpredictable burden of medical and surgical catastrophies by developing meas-

ures for deferred payments and hospital insurance.

Raised Standards of Practice—Today there are fewer incompetents in the profession than ever before. Mortality and morbidity rates were never lower. During the past five years more than two-thirds of the members of the Society have voluntarily taken post-graduate training of one kind or another. This record is unmatched by any country that has replaced the competitive form of medical practice by any form of socialized medicine. While there are always some mercenary persons who graduate as physicians and who would make disease a commodity, today we believe the number of such men is fewer than ever. The open purpose of the Society to protect the public from them has discouraged attempts at exploitation.

Adjusted Fees—Because of the continued economic distress and unemployment, the profession has adjusted fees to relieve financial embarrassment by patients. When the problem of unemployment is solved, medical problems which are its correlaries will be solved. When the Government lowers its cost, balances its budget, and permits business to revive, the problem of unemployment may be solved. Certainly government relief has not solved it, and certainly business cannot revive so long as it must pay taxes to a government that competes against it tax free. It is the proper function of the government to regulate business and to promote public health, but not to engage in business or to practice medicine. In this land where freedom of speech has been preserved, may we therefore suggest without fear of government reprisals that the government spend its energy and substance in correcting continued economic distress, rather than in promoting politicalization of medicine after the manner of totalitarian countries?

Legislation—Cults and agents swarm the legislative halls in Trenton, and sponsor subversive bills which must be defeated if the public is to be protected. The Medical Society of New Jersey has guarded the welfare of the public for many years. If it were to relax its legislative vigilance for a moment, a medical diploma which connotes years of training would become a worthless scrap of paper. But what is much more serious, a horde of untrained pretenders would be licensed to prey on the unsuspecting public. It is not the aim of organized medicine to monopolize the treatment of the sick, or to dictate means and methods of cure. But it is our duty to point out that public welfare demands that all who are licensed to treat the sick shall receive training enough to recognize ailments which they at-

tempt to treat. If the proposed Medical Practice Act, A-210, is monopolistic and unfair to a minority, then the Bureau of Weights and Measures is monopolistic.

Legal Standards—For the past five years the Society has attempted to secure a Uniform Medical Practice Act. Last year without the united support of all of our members, and in the face of opposition by several county societies, the Act passed the Assembly, but it died in a Senate committee. This year by the omission of all reference to contract practice, the new Medical Practice Act, A-210, has unanimous medical endorsement. If our members fully explain the Bill to their Senators and Assemblymen at home, we may yet see the adoption of the long-sought Bill.

Patent Medicines—The cost of illness is pyramided by the widespread use of fraudulent patent medicines. The most effective means to protect the public against this waste is *education*. The State Society is furnishing countless speakers to lay groups on this and allied matters. Many patent medicines of today were the proprietaries of yesterday. The Medical Society, in coöperation with the New Jersey Pharmaceutical Association, revised and republished this year the New Jersey Formulary, the wide use of which is materially lowering the cost of prescriptions and hence the cost of illness.

Insurance—It is now the general custom for the members of the Society to accept deferred payments from patients in need who are confronted with catastrophic illness. The first group hospital insurance plan to be placed in operation in the United States was started in Newark with representatives of The Medical Society of New Jersey on its Board. Membership in this three-cents-a-day plan has increased by leaps and bounds, and now numbers over 110,000.

Many private insurance companies are selling medical care insurance. This year two committees of The Medical Society of New Jersey studied non-profit medical care insurance and laid down broad principles. A third committee is now attempting to put a plan into operation on an experimental basis.

3. SOCIALIZED MEDICINE

The third administrative policy of the year was to *protect the people of New Jersey, rich and poor alike, from costly, impersonal, socialized medicine in any form*. During the past twelve months more attempts have been made to politically socialize medicine than in any other year in history. These attacks on the private practice of medicine have varied all the

way from power drives by Federal forces, down to sniping carried on behind our own lines. Scarcely a week has passed that some group or individual from without or from within has not attempted to weaken or destroy the American system of the practice of medicine,—the system which grants liberty-loving people the right to engage physicians of their own choice,—the system which has stimulated the greatest medical progress ever known to mankind. However, proponents of politicalized medicine have failed to capture the citadel, and their attacks have actually strengthened our defense. Doctors are preoccupied and not easily aroused. But they are now coming to realize that their enemies have struck their tents, and are on the march. Politically, doctors themselves constitute an insignificant minority, but they have powerful allies and legions of reserves. Thinking men and women are our allies, and grateful patients are our reserves.

4. THE LOW-WAGE GROUP

In order to preserve the principle of free choice of physicians for the low-wage group, doctors have lowered their fees in proportion to patients' incomes, thus permitting those of modest means to retain self-respect, self-reliance, and independence. The battle is not over. Because of widespread economic distress, too many who are undeserving find ways to obtain free treatment; and many who are ineligible are directed by social agencies to clinics meant for the indigent, thereby crowding out those who deserve clinic care, and for whom no other facilities are available.

5. SUBSIDIZED CARE OF INDIGENTS

The fifth administrative policy of the year was to secure State aid in the care of the indigent while at the same time preserving for them the free choice of physicians.

The care of the indigent is the dual responsibility of the State and the profession. From figures gathered in our State-wide survey of New Jersey, it is estimated that the physicians of New Jersey rendered \$24,389,730 worth of service last year to the indigent without financial remuneration. This is based on 835,640 free office and home calls, by 4630 physicians. If these home and office calls were remunerated at E. R. A. rates of \$2.00 and \$1.00 each, this would amount to \$5,013,890. In addition, services estimated to amount to \$9,053,840 were rendered in hospital wards and clinics. Finally, if all free operations, major and minor, regardless of extent, were remunerated at the flat rate of \$25.00, one must add the staggering sum of \$10,322,000, making a total of \$24,389,730 free professional services by the phy-

sicians of New Jersey to the needy. This averages more than \$4000 for each practicing doctor in the State. These figures, based on available data, show that doctors are giving their services liberally to the poor. The cost of clinic and hospital facilities for the care of these unfortunates has been added to the hospital bills of pay patients. Why should the self-supporting who are ill be made to bear the bulk of the burden? The care of the indigent is clearly the duty of the entire tax-paying public. The Medical Society of New Jersey is now ready to supervise, direct, and furnish efficient service at reduced cost to the indigent the moment State funds are made available. This is not an untried theory, but a sound economical method proved workable in New Jersey during the Emergency Relief Administration in 1934 and 1935.

6. ADVANCING MEDICAL PRACTICE

The sixth administrative policy of the year was to advance the science and art of the practice of medicine by inaugurating a Clinical Session, by promoting post-graduate study, by enlarging and enriching the scientific program and the scientific and technical exhibits at the Annual Meeting, and by further improving the Journal.

Clinical Session—For the first time in its history a clinical session was planned for The Medical Society of New Jersey. With the help of the Essex County Medical Society and the Academy of Medicine a two-day session was held in Newark on October 6th and 7th, 1938, with ward walks, clinics, panel discussions, and conferences designed particularly for the family physicians of New Jersey in order to keep them abreast of rapid scientific progress. The Clinical Sessions was attended by 890 members. It is recommended that clinical sessions be continued in the years to come.

Post-graduate courses are now being held throughout the State and data upon attendance and interest is not yet available. It is safe to say that no profession compares with medicine in the number of its members who annually seek to improve their professional knowledge and skill. But this is true only in a nation dedicated to free enterprise, and stimulated by wholesome competition. Totalitarianism stifles post-graduate work. Under it medicine becomes static.

Annual Meeting—The success of the 173rd Annual Meeting is in the lap of the gods, but it will be held in Haddon Hall in Atlantic City on June 6th, 7th, and 8th. Already every allotted space has been assigned for scientific and technical exhibits. There is every indica-

tion that the attendance, program, and scientific discussions will establish new records.

At the beginning of the administrative year the policy was adopted of selecting scientific articles for the Journal that met the needs of the *general practitioner* rather than the specialist. Each speciality has its own publication. A review of the issues of our Journal for the year will reveal the fact that this objective has been attained.

7. ELEVATING STANDARDS

The seventh administrative goal was to elevate the standard of our professional practices by maintaining and expanding those which are our rich heritage from our predecessors, and increasing the membership of the Society to include every ethical and duly licensed physician in New Jersey.

Because doctors are human, it is reasonable to suppose that some actions of some doctors at some times would not meet the criterion of perfection which we have set before ourselves. However, I am happy to report that the five judicial councilors have not had to discipline a single member of the Society this year. One might expect diminishing professional returns to increase sharp practice and unethical conduct.

The membership of The Medical Society of New Jersey has increased from 3540 (as of March 15, 1938), to 3613 (as of March 15, 1939), yet there are 1634 physicians in active practice who are not members of the State or County Society. A large number of these non-members meet the required professional and ethical standards. It is our duty to point out to them that they owe it to themselves and to the public to join forces with us. Only a solid front will preserve the private practice of medicine.

8. MEDICAL FELLOWSHIP

The eighth administrative policy of the year was to promote friendly understanding among doctors of the State by:

- a. Fair representation of all groups on the several committees which formulate the policies and carry on the activities of the Society;
- b. By promoting the fellowship of service which grows out of increased contacts in the committees;
- c. By more frequent visits of members to the meetings of neighboring county societies;
- d. By reestablishing inter-county meetings in each Judicial District;
- e. By fostering friendly contacts in these meetings, and at the Annual Meeting.

At the beginning of the year the officers of the twenty-one county societies were asked to

recommend able and willing men for State Society work. If there has been unfair representation of any group, and I know of none, it has been due to the fact that not all counties made recommendations.

Fellowship—A great fellowship of service has grown out of contacts resulting from increased committee work this year. More than two hundred active, able, alert, interested doctors have devoted long hours to the problems presented to our thirty-four committees. The State Society has set a record in capturing the enthusiastic heart interest of hard-working, self-sacrificing men. The personnel of the committees this year is a *roll of honor* for service rendered.

Visitations—Friendly understanding has been increased by more frequent visits of members to the meetings of neighboring county societies.

Inter-county meetings have been reestablished in each of the five judicial districts, where friendships were kept in good repair. Bickering, provincialism, and misunderstanding have been replaced by unity, harmony, and mutual understanding.

We look forward to the 173rd Annual Meeting of the State Society as a friendly gathering of professional folks who know, and understand, and respect one another. There is so much scientific advance yet to be made, and so many enemies are storming the gates without, that the Society can ill afford to dissipate its energy and influence by internal strife.

9. PUBLIC RELATIONS

The ninth administrative policy was to promote mutual understanding between physicians and the public by means of articles in local newspapers and magazines and by radio talks.

There have been ninety-six press releases, eighteen magazine articles, and twenty-six radio talks by members of the Society; besides many exhibits, pamphlets and miscellaneous public relation activities, including the distribution of 60,000 stickers to school children relative to appendicitis. Ninety-four addresses have been made by our members before interested lay groups; and doctors of the State have participated in countless welfare and political activities.

10. ASSISTING COUNTY SOCIETIES

The tenth administrative policy was to render greater assistance to the component county societies by official visits to each by officers of The Medical Society of New Jersey, by a training course for the officers of county societies, and by the promotion of a more thorough two-way flow of ideas and suggestions between

the State and the county organizations through the Welfare Committee.

To date the President and his Cabinet have made forty-five *visits to county societies*, and there are two more months in this administrative year. All will have been visited.

A training course for the officers of county societies was arranged, financed, and conducted by the State Society in Trenton on September 11th. Sixty men attended this meeting, and every county was represented. This was the first of its kind held in organized medicine.

It is recommended that this round-table training be continued, enlarged and perfected. It is fundamentally sound.

Five meetings of the *Welfare Committee* have been held to date, with an average attendance of fifty-four. More men now attend the meetings of this one committee than were present at the sessions of the Annual Meeting of the Society when your President became a member in 1910.

11. RECOGNIZING MERITORIOUS SERVICE

Another administrative policy was to give public recognition to physicians who have practiced more than fifty honorable years, and to members of our profession who have made outstanding contributions to science, research, and art, and to political and civic life.

These recognitions will be made at the coming Annual Meeting.

12. PERFECTING MEDICAL ORGANIZATION

The twelfth and final administrative policy was to improve further the organic structure of the Society by:

A. Appointing, as chairmen, vice-chairmen, and members of the several committees, only those men who had pledged their willingness to give active service;

B. Synchronizing the meetings of the Advisory Committees, the Welfare Committee, and the Board of Trustees, all to meet on pre-arranged schedules, so that recommendations could be made, considered, and accepted or rejected without delay;

C. Securing committee activity by—

1. Fixing the dates of their meetings at the beginning of the administrative year;

2. Reimbursing all those who served the Society at the rate of five cents per travel mile;

3. Publishing the personnel of next year's committee at the close of the Annual Meeting in order to avoid loss of time and momentum.

D. Expediting the transaction of Trustee business by the appointment of Board committees for preliminary study of its numerous and intricate problems;

E. Avoiding unnecessary meetings and re-duplication of effort;

F. Adding two new advisory committees,—one on Industrial Injuries and Occupational Diseases, and the other on Traffic Safety.

Without exception these administrative innovations were carried out; and they have seemed to work well.

This concludes the comparison, item by item, between the President's program as planned last May and as completed to date (April 16, 1939).

ANNUAL REPORTS

The annual reports of the Trustees and committees, which appear in this issue of The Journal, speak volumes for themselves. However, the year's work of the officers and committees is not yet completed, but will be continued as aggressively as ever. During the month of May the three major objectives will be:

1. An intensive effort to enroll every eligible doctor in New Jersey in the ranks of organized medicine.

2. The completion of the assigned work of the Governor's Health and Welfare Conference.

3. The inauguration of medical care insurance on an experimental basis.

RECOMMENDATIONS

With no thought of prescribing or dictating the policy of the succeeding administration, the following recommendations are submitted: 1, coöperation; 2, rejuvenation; 3, administration; 4, evolution; and 5, distribution.

CO-OPERATION WITH THE FEDERAL GOVERNMENT

It is our duty to coöperate with those Government officials whose purposes have not been proven to be less altruistic than our own. The health aim of the Federal Government and the medical profession is one and the same,—adequate medical care for all people whether they live on an avenue or in an alley. But the Government accuses the profession of *Monopolistic Toryism*; and the profession accuses the Government of an attempt to sabotage scientific medicine by placing doctors and the sick under the control of politicians. We deplore these recriminations which have kept us apart. Surely we have advanced far enough from the Neolithic age so that reason shall rule. Where aims are mutual, methods can be devised without compromise of principle.

CO-OPERATION WITH THE STATE GOVERNMENT

There is perfect understanding in New Jersey between the various departments of the State Government and the medical profession.

We see eye to eye, and are working hand in hand. This close coöperation, which is an example and an inspiration, should be continued.

CO-OPERATION WITH OTHER PROFESSIONAL GROUPS

The Society should continue to enrich its harmonious contacts with the New Jersey State Dental Society, the New Jersey Pharmaceutical Society, the New Jersey Bar Association, and the various nursing organizations.

CO-OPERATION WITH THE AMERICAN MEDICAL ASSOCIATION

In New Jersey the percentage of physicians who are Fellows of the American Medical Association is greater than in any other state of the Union. Differences of opinion are bound to arise between the American Medical Association and its component State Societies, just as differences arise between the State Society and its component county societies. May that day never come when our thinking will be regimented; but in these times it is vital that all differences be adjusted *within organized medicine* and not before lay groups and in the lay press. There are those who would divide us and destroy us. Self-preservation demands a united front.

CO-OPERATION WITH SOCIAL WORKERS

At heart social workers and doctors are humanitarians. There is a solution, therefore, to the problems which have arisen from differences in points of view. Social workers and doctors are both *necessities*; and they can work best side by side when there is complete understanding and accord. More frequent round-table group discussions are needed.

REJUVENATION

The average age of the officers of The Medical Society of New Jersey is sixty-one years. The Trustees average fifty-eight years; and the committeemen fifty-five years. Except necrology, there is no medical problem, scientific or economic, that does not concern the younger members of the profession more than those for whom the shadows are lengthening. The form and substance of the practice of medicine in years to come are being fabricate by organized medicine today. It should be our policy, therefore, in so far as possible, to give youth the voice, the vote, and the training for leadership.

ADMINISTRATION

In order to increase efficiency, the administrative years should run concurrently. At present the administrative year begins in June; the dues year in January; The Journal year in

May, and the component county societies on four other dates. All this is confusing and should be corrected.

The officers of all component county societies, regardless of the date of their election, should assume office immediately after the close of the Annual Meeting of the State Society. This is now done in Atlantic, Bergen, Burlington, Cumberland, Hunterdon, Mercer, Somerset, Sussex, and Warren Counties.

Camden, Essex, Gloucester, Hudson, Ocean, Passaic, and Salem install their officers in May; Cape May and Middlesex in January; Monmouth and Union in April; and Morris in June.

It is highly desirable that the terms of State and county officers run concurrently. By and large, the weakest link in the chain of organized medicine is the county society. Concurrent administrations will permit the expansion and perfection of the annual training conference for county officers by the State Society, and closer and more personal contacts throughout the year.

LEGISLATION

Unless an overwhelming majority of our members desires legislation and is willing to fight for it, we should proceed with caution in the introduction of new bills. Legislative work costs time and money. May we never see the energy and substance of the Society dissipated in the attempt to secure legislation to which the profession is indifferent.

EVOLUTION

Medicine must continue to make progress by *evolution* rather than by *revolution*. The Medical Society of New Jersey should continue to enrich its Annual Meeting by means of practical scientific papers, exhibits, and discussions; and should make the Fall Clinical Session an annual event. Post-graduate courses under the auspices of the Medical Society and Rutgers University should be made even more attractive than in the past.

DISTRIBUTION

The medical profession must improve the distribution of its services so that adequate care is available for all the people. If we fail, Government control and compulsory health insurance, with their attendant ills, are inevitable. There is now ample care for the sick who can afford it. Doctors are now doing well by the indigent. Last year the profession in New Jersey alone gave gratuitous service to them conservatively estimated to be worth \$24,000,-000. The Medical Society of New Jersey is now ready to supply complete service to all the poor the instant New Jersey realizes their care is the dual responsibility of the profession and the State. However, the proud, independent, self-supporting middle class want none of charity. Since they are hit hard by unpredictable and catastrophic illness, the profession must protect them by non-profit medical care insurance.

Finally, we should establish *coöperative diagnostic clinics* in our communities, large and small. Ninety per cent of illnesses can be promptly diagnosed by the family physician with no more instruments than can be carried in a small handbag. Ten per cent of illnesses, however, are complicated, and require special skill and equipment in their diagnosis. Where there are several doctors in a community, they ought to pool their knowledge for the early diagnosis of puzzling cases. The location of the clinics; the fees, which should be adjustable; and the remuneration of participating physicians;—all will have to be determined by local conditions. In metropolitan areas, these diagnostic clinics would furnish specialists of all types. In smaller communities, specialization would of necessity be limited. In either case, the clinics must be *wholly diagnostic, never therapeutic*; they must accept cases only on the written request of the attending physician; and must return them to him for treatment.

THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS TO THE HOUSE OF DELEGATES

June 6-8, 1939

PART ONE INTERNAL AFFAIRS

EXECUTIVE OFFICER'S ANNUAL REPORT

By LEROY A. WILKES, M.D., Trenton, N. J.

To the President:

The work of the Executive Officer and staff of The Medical Society of New Jersey can best be visualized when our members appreciate that modern medical practice consists of two essentially different types of service. The Executive Officer, who serves the Society, must also fully understand, preferably as a result of actual participation in professional medical practice, our medical ethics and the processes of thought and procedure followed by doctors of medicine.

EXECUTIVE SERVICES

The Executive Officer must, however, be primarily a well-trained and experienced executive, such as we find in charge of a modern efficient hospital or a well-run health department. He is trained in business methods. No amount of professional medical training or private practice of medicine *alone* will develop an executive type of mind. Neither will private practice furnish the experience necessary in such procedures as survey methods; processes for gathering and analysis of data; the bases of economics; the formulation of programs and plans, schedule making and dispatch; and the many and varied details by which the practicing physicians' services are distributed economically and effectively to the public—in a manner mutually advantageous to the profession and to the public. The constant defense of the medical profession through public speeches, legislation, and sometimes against deliberate and malicious misrepresentation, as well as misinterpretation when honestly based on misinformation, is especially necessary at this time.

The professional services of the physician furnished to the patient at his own request, is not being seriously attacked by the public—in fact the growing demand for wider distribution of the physicians' services is that these services themselves be more widely distributed

and that the cost thereof also be distributed over time and persons. This demand is a sign of appreciation and approval by the public.

The costs of adequate medical care are not low. These costs probably cannot be greatly reduced in amount but the payment for such services can be better distributed through such aides as private philanthropy, public taxation for the indigent and the low-wage group (who move irregularly in and out of indigency). For those who can provide for themselves, if assisted by proper financial plans based on the installment or on the insurance principle, improvement can and should be further provided. Here the "Business Department" of The Medical Society of New Jersey can aid the House of Delegates, and the Board of Trustees ad interim, in the collection and interpretation of existing factual data on medical economics and distribution gathered from earlier experiments in this country and abroad.

The assistance of well-chosen representatives in the community who are recognized "specialists" in insurance, law, finance, and health administration, and also in welfare services, both public and private, in discussions on these special aspects of the tentative proposals of the Medical Society, should be of great help in establishing and meeting the health needs of the public, through ways and means approved by all; and should show us how to effectively integrate the special contributions of the members of each community agency.

We are now in a coöperative era. The individual who does not do his share as a professional and community-group worker, as well as an individualist, is likely to go down in the struggle, gloriously perhaps, but chiefly because of the odds against him in the trends of today.

BUSINESS OFFICE

This report then is a brief résumé of the work of the "business office" of the Society

which carries out, as economically and effectively as possible, the duties with which we are charged.

The *aims and plans* for each administrative year are outlined by the President and the Board of Trustees. When the members, who are represented in the House of Delegates, have approved these plans, and also the budget based on an estimated cost for the year, it is the function of the Executive Officer and staff to begin to put in motion the machinery by which the wishes of the Society are translated into action through the members' own participation. Our present weak spot is the inertia in our Component Societies, which lack the "machinery" to get things done—promptly.

Here is our biggest job.

The funds collected are held by the Medical Society's Treasurer, except for a small month revolving fund held in the bank in Trenton for routine office expenses, and these expenditures are accounted for at the end of each month to the Finance Committee and the Treasurer. All accounts are audited monthly by licensed auditors.

Most of the incoming and outgoing correspondence of the Society, its officers and staff, the editorial staff, committees, etc., clears through the Executive Offices. Much of this correspondence deals with routine inquiries, reports, requests for information, investigations, reprints, reports of committees, addresses of organizations and individuals, schedules, rules and regulations re medical examiners, health departments, welfare departments, legislation, etc. It comes chiefly from our members, but also from other agencies and individuals in New Jersey. In addition we have constant touch with federal departments and other State groups and medical societies, and personal contacts, bulletins, and literature which keeps us informed on national, State and local issues having health implications.

LEGISLATION

Legislative follow-up consumes from one-quarter to one-third of the time of the Executive Officer during the legislative term—probably a little less when no bill is being sponsored by The Medical Society of New Jersey.

Sponsoring a bill of our own makes it doubly hard to oppose other bills for we lose support for our own bills at times when we oppose others introduced by legislators whose support we endeavor to enlist. Not only is a large amount of time devoted to legislation by the Executive Officer, but also by the Legislative Committee members and the keymen, the officers of the county societies and individual members whose support is so urgently needed

and enlisted. Telegrams and telephone costs increase greatly during legislative season because time is an essential element due to frequency of change of attitude of legislators and the day on which bills are to be voted upon. In this connection may I emphasize that, during the entire year, a considerable economy can be effected by prompt replies to our letters sent to officers and committee members. Additional letters, telegrams and telephone calls will not then be necessary in order to get a reply, and the cost thereof can be curtailed. We in the Executive Offices serve—we cannot command nor discipline those whom we serve, as in the case of Government-controlled "State Medicine".

ADMINISTRATION COSTS

Better organized effort, more concentration on immediate objectives clearly understood, quicker action on Society projects, prompt and informative reports, an attitude of helpful co-operation in mutually approved and beneficial programs, and a willingness to provide reasonable finances based on the current needs rather than upon former budgets will retain in the hands of the profession the freedom of choice, liberty of action and self-confidence and unity which is essential to success. If we physicians fail to provide and support these essentials, others will, and to them will go the "freedom of choice"; the "intervention between physician and patient". The "method of payment of indigent care", "separation of medical needs from cash benefits", and many other problems of this day and age will be taken gradually out of the hands of the profession by that group who *will* pay the costs involved.

The costs of administration and conduct of the affairs and activities of the Society per capita are, I believe, not likely to be much lower for some time if the profession will control its own affairs. These costs will, however, soon begin to be distributed as the larger county societies set up "business offices" similar to those of the State Society. In another year our exploratory phases will be largely over, and we can concentrate upon essential and long-time projects to be developed in an evolutionary way. Some economies will then be possible and desirable.

We cannot afford to retrench too much at this time, else we may lose much of the big investment already made, and the trends toward Federalization of Medical Services may become accelerated. If each member were to save two or more dollars in dues per year it might be the most expensive "economy" ever achieved.

Some of the activities and contacts are appended below:

1. Twenty-seven visits to county medical societies' meetings were made.
 2. Speeches on "Socialized Medicine" to intelligent civic, social and political groups in Trenton, Rahway, and Princeton.
 3. Constant coöperative conferences with:
 - a. Department of Health and its divisions, especially Communicable Diseases, Maternal and Child Health, Venereal Disease, and Local Administration.
 - b. Department of Institutions and Agencies, especially Board of Children's Guardians, Medical Service and Statistics, Old Age, and Mental Hygiene.
 - c. Department of Labor—Rehabilitation and Workmen's Compensation.
 - d. Department of Motor Vehicles—Special studies to detect drunken drivers and discovery of potential health hazards in drivers. Secretary to Advisory Committee.
 - e. Crippled Children's Commission—Member of Advisory Committee.
 - f. New Jersey Sanitary and Health Association—Member of Executive Committee.
 - g. New Jersey Hospital Association—Member of Executive Committee and Legislation Committee.
 - h. New Jersey Tuberculosis Health League—Member of Program Committee and Board of Directors.
 - i. Governor's Conference of Health and Welfare—
 1. Child Health Committee.
 2. Crippled Children's Committee.
 3. Administrative Coördination Committee.
- N. B. Many meetings of this conference required many hours of time and effort but the Medical Society's contributions are proving to be most valuable.

- j. District meetings (4) were attended.
- k. Social Worker's Council—Member of Board of Directors and Program Committee.
- l. State Chairman for the New Jersey American Academy of Pediatrics.
- m. Member of White House Conference on "Children in a Democracy".
- *n. A. M. A. Survey in New Jersey.
- *o. Voluntary Health Insurance studies.
- *p. Hospital Relationship study.

*In the last three activities Dr. Norman M. Scott, Executive Assistant, has done excellent work and is now ready to be of most valuable assistance to the Society as a whole. Your Executive Officer attended the Special Session of the A. M. A. at Chicago, the American Academy of Pediatrics at Rochester, and the White House Conference in Washington.

An idea of the spread of activities of the girls in the Executive Offices can be gained through a glance at the following statistics:

1. Incoming mail	3,785 pieces
2. Outgoing mail	46,228 pieces
3. Mimeograph Material—	
Stencils cut	664
Sheets mimeographed	119,973
4. Sunday meetings held	137 committees

Minutes of all meetings reported are mimeographed and distributed to committees after the meetings.

Agendas for the meetings are sent out prior to the meetings.

Respectfully submitted,

LEROY A. WILKES, M.D.,
Executive Officer.

REPORT OF THE SECRETARY

By ALFRED STAHL, M.D., Newark, N. J.
Portrait, page 256

To the House of Delegates:

Your Secretary desires to extend felicitations to all the members on the 173rd Annual Meeting of The Medical Society of New Jersey.

MEMBERSHIP

On March 15th, 1939, our Official List consisted of 3,613 members, of which 3,473 were active members, and 140 were associate members. This is an increase of 129 over the membership as of March 15, 1938. There were forty-two deaths and twelve resignations; transfers from other states, nine; transfers to other states, nine; transfers within the State, fourteen; new members admitted in 1939, 188;

former members failing to pay 1939 dues before March 15, 1939, 403; physicians of New Jersey not members of Medical Society of New Jersey, 1,231.

BROADENED ACTIVITIES

The activities of The Medical Society of New Jersey are increasing by leaps and bounds each year. No longer are the activities of the individual doctor a strictly private affair between the doctor and the patient. Washington has definitely stated that the health of all the nation is the direct concern of the government. With that attitude on the part of the government, organized medicine becomes the medium to protect the rights of the individual doctors,

as well as those of the public. It is this economic side of the practice of medicine that makes necessary the ever-increasing activities of the State Society.

MEETINGS

Your Secretary attended all the regular and special meetings of the Board of Trustees and all the regular and special meetings of the Welfare Committee. These meetings have been far more numerous than in past years.

In an advisory capacity your Secretary attended the meetings of the Publication Committee, and the meetings of the Committee on Auxiliary Medical Services.

In company with other officers of the State Society conferences were had with Congressmen, as well as members of the State Legislature.

On invitation from the American Medical Association, your Secretary attended the Special Meeting of the American Medical Association last September in Chicago. Reports of that meeting appeared in the State Journal in the October, 1938, issue, page 614.

Numerous County and Councilor District meetings were attended by your Secretary.

TRANSACTIONS OF THE HOUSE OF DELEGATES

The transactions of the Annual Meeting for 1938 were edited so as to eliminate unessential details, cutting down the volume of the transactions materially, at a decided saving to the Society in printing. At the same time, the transactions were more clear and understandable. It is the intention of the Secretary to continue the editing of the transactions for the coming year. A copy of the 1938 stenotyped verbatim report of the proceedings will be on exhibition at the convention, and thus available to all who wish to see the original verbatim transactions.

OFFICIAL LIST OF MEMBERS

In compiling the Official List this year, your Secretary eliminated some sections that in previous years appeared with the Official List. Your Secretary confined the publication to listing the fellows and honorary members, and active and associate members in good standing, as of March 15th, 1939. The names appear in

an alphabetical list, and also according to counties. This procedure has made possible a saving in printing of some \$80.00.

CONSTITUTION AND BY-LAWS

The printing of the revised Constitution and By-Laws of The Medical Society of New Jersey in the February, 1939, issue of the State Journal, instead of printing them in booklet form for each member, made possible a saving of almost \$200.00. In addition to printing the Constitution and By-Laws in the Journal, we have reprints in booklet form for the officers and others who may desire it in this form.

RECOMMENDATIONS

Your Secretary desires to submit the following recommendations for your consideration:

1. That the Welfare Committee of the State Society be composed of the President of each county society, the chairmen of the standing committees, and the Officers and Trustees of the State Society. Under this set-up, a more intimate relationship between the county societies and the State Society would be established. The official attitude of the county societies on pending matters would be brought to the State Society, and the county societies would have the deliberations of the Welfare Committee at first hand. Business coming before the State Welfare Committee would thus be handled with far greater dispatch, and would obviate the necessity of some special meetings of that committee.

2. In view of the political and economic conditions prevailing, it would be advisable that closer and more intimate relationship be systematically established between The Medical Society of New Jersey and the members of the Board of Medical Examiners, whose appointments are made at the recommendation of the Society. The income of the Board of Medical Examiners is derived from fees paid by licensees that come before this Board, and from fines collected. This has its obvious disadvantages, and remedial measures should receive consideration by The Medical Society of New Jersey.

Respectfully submitted,
ALFRED STAHL, M.D.

REPORT OF THE FINANCE AND BUDGET COMMITTEE

The Finance and Budget Committee will present its annual report directly to the House of Delegates in the form of a supplementary report.

HARRY R. NORTH, *Chairman.*

REPORT OF THE TREASURER

The fiscal year of the Society does not close until May thirty-first. A complete financial report will be presented directly to the House of Delegates.

E. J. MARSH, *Treasurer.*

REPORT OF THE BOARD OF TRUSTEES

By RALPH K. HOLLINSHED, M.D., Westville, N. J.

To the House of Delegates:

Under the efficient executive and administrative leadership of the President of The Medical Society of New Jersey, the Board of Trustees has had a busy and productive year.



WELFARE COMMITTEE MEETINGS

Each member of the Board of Trustees, in addition to being a consultant to one or more of the appointed committees of The Medical Society of New Jersey and meeting with these committees in an advisory capacity, has at the request of the President been present at the meetings of the Welfare Committee. In doing this the members of the Board of Trustees are in close touch with what is going on in the Society.

This procedure has, however, somewhat handicapped the Board in the transaction of its official business because of the time factor. While we believe it to be a good thing for the Trustees to attend the meetings of the Welfare Committee, we cannot help feeling that, after attending committee meetings in the morning, and the Welfare meeting at two o'clock, the Trustees are not in a particularly favorable physical or mental state to go through with the usually long and important agenda of their own meeting.

We therefore suggest that for the coming year some arrangement be made so that this condition may be corrected.

THE AGENDA FOR MEETINGS

The agenda for meetings of the Board of Trustees have been carefully prepared, and all matters that require study have been referred to the proper committee before they are presented to the Board.

The Board should meet in the Executive Offices early enough in the day so that the business may be given proper consideration by men who are mentally alert, and who do not feel that they must hurry to make a train.

THE ANNUAL ASSESSMENT

Due to the progressive policies of the administration, the necessity of employing an Executive Assistant, the Governor's Conference, the Annual Clinical Session, the A. M. A. Survey, the special meeting of the A. M. A. delegates, the expenses of the Committee on Voluntary Health Insurance, and the appointment of a Legislative Agent, a considerable sum of money has been appropriated. This may mean an increase in assessment.

We feel, however, that these expenses are justified under the present conditions if New Jersey is to retain its leadership in medical affairs. Provision should be made in the budget so that we may still go forward.

RECOGNITION OF OFFICERS

At the reorganization meeting on May 19th, 1938, recognition was made of Dr. Nafey's long term of service as Secretary of the Board of Trustees.

The duties of the Executive Officer, the Secretary of The Medical Society of New Jersey, and the Secretary of the Board of Trustees have been defined so that in the future there need be no confusion or duplication of effort.

Suitable resolutions were prepared after the death of Dr. Henry O. Reik, former Secretary of The Medical Society of New Jersey, and a copy was sent to his family. (Jour., June, 1938, p. 390.)

IMPORTANT ACTIVITIES

At the meeting on August 7th, 1938, special attention was called to the reports of the Delegates to the A. M. A., which appeared in the State Journal of July, 1938, pages 439-444.

The Report of the Special Committee on Clinical Session held in Newark October 6th and 7th was approved, and its program was endorsed by the Board, and subsequently by the general membership of the Society.

The question of Executive Assistant was freely discussed. Dr. Norman M. Scott gives evidence of ability which leads us to believe that his selection was a wise choice.

A history of The Medical Society of New Jersey by the Editor of the Journal, under the supervision of the Publication Committee, was determined upon, and the collection of data is well under way.

The National Health Conference and the A. M. A. Survey were freely discussed, and

full coöperation has been given in the studies which were begun at Governor Moore's request, and those which were included in the A. M. A. survey.

On September 11th, 1938, a special meeting was held with the Delegates to the A. M. A. to discuss the approaching meeting of the House of Delegates of the A. M. A. and to outline a plan of action. Drs. Mulford, Eagleton, Read and McBride were authorized to attend the special meeting of the A. M. A. on September 16th, 1938, and Drs. Carrington, Snedecor and Lewis were sent as observers. Dr. Stahl, as Secretary, and Dr. Wilkes, in the place of Dr. Overton as Editor, attended at the invitation and expense of the A. M. A. Their reports have been published in the Journal. (October, 1938, pages 614-626.)

Some time was devoted to a discussion of the New Jersey Health Conference (Journal, Dec., 1938, p. 751); and subsequently thirty-five of our members accepted the Governor's invitation to serve on the various committees.

The meeting on October 2nd, 1938, was marked by the decision of the Board to engage a Legislative Agent.

Suitable recognition of the death of Dr. Philip Marvel was unanimously approved.

It was decided that the Trustees should meet with the Welfare Committee for an hour, before proceeding with their own meeting.

A special meeting on October 30th, 1938, recommended the name of Dr. Rector to the Governor for appointment to the Board of Medical Examiners. He was appointed and served until his untimely death.

The Board of Medical Examiners were the guests of the Board of Trustees at its regular meeting on December 4th, 1938, and considerable profit resulted from the free exchange of ideas which took place at this meeting.

Suitable recognition was taken of the death of Dr. James J. McGuire, Secretary of the State Board of Medical Examiners.

Due to the great number of changes made in the Constitution and By-Laws, it was decided to have them reprinted; and a copy was furnished to each member of the Society by having them included in the Journal.

Dr. W. L. Wilbur, Hightstown, was recommended to the Governor for appointment to the State Board of Medical Examiners together with the names of Drs. Frank Scammell and Harry R. North of Trenton as second and third choice for appointment.

A special meeting was held on January 8th, 1939, to give further consideration to Governor Moore's Health Conference proposals.

At a special meeting on January 22nd, 1939, Dr. Elmer P. Weigel was recommended to the

Governor for appointment to the State Board of Medical Examiners together with the names of Drs. John H. Rowland and Samuel Barbash as second and third choice for appointment.

At a regular meeting on February 19th, 1939, Dr. Sprague presented an interesting report for the Committee on Voluntary Health Insurance (Journal, March, 1939, page 165). The report showed that the subject had been studied at length. Considerable progress has been made toward a solution of the problem, but further investigation is necessary.

The recommendations of the committee were approved and an appropriation not to exceed \$1000 was made to assist the committee in carrying on the work. In addition to the present members it was decided to enlarge the committee to include two representatives from each Judicial District.

Dr. Pollak, Chairman of the Legislative Committee, spoke of the changes that had been made in the Uniform Medical Practice Act before its introduction. These changes and the action of the committee were approved.

The question of employing a Legislative Agent was referred to the Special Committee with power to act.

Dr. Carrington reported on the Cancer Control Conference. This committee will be continued until the results of further investigation are heard from.

Dr. Lewis presented a report from the special committee to study Cases of Sex Perversion. His report was most comprehensive and is printed in the Journal of March, 1939, page 170. The recommendations of the committee were adopted.

The cost of printing and distributing the Constitution and By-Laws to the members was referred to the Finance and Budget Committee.

The Trustees approved the resolution presented by the Bergen County Medical Society regarding the medical care of wards of the Board of Children's Guardians.

The name of Dr. Henry B. Diverty was sent to the Governor for reappointment to the State Board of Medical Examiners together with the names of Drs. William W. Pedrick and Oran Wood, as second and third choice for appointment.

The Legislative Committee was requested to vigorously oppose the passage of a special Bill, A-62, which is designed for the benefit of one applicant for a license to practice medicine.

RALPH K. HOLLINSHEAD, *Chairman*

ALDRICH C. CROWE, *Secretary.*

COUNCILORS' REPORTS**THE FIRST COUNCILOR DISTRICT**
Essex, Union, Morris and Warren Counties

By CHRISTOPHER C. BELING, M.D., Councilor
Newark, N. J.

To the House of Delegates:

The county medical societies have been maintained at a high level all through the year, and there have been no matters of ethics or of a judicial character referred to the Council for consideration.

THE SECOND COUNCILOR DISTRICT
Bergen, Hudson, Passaic and Sussex Counties

By VINCENT P. BUTLER, M.D.
Jersey City, N. J.

To the House of Delegates:

A meeting of the Second Councilor District was held in Jersey City on the evening of December 15, 1938, beginning with a social dinner in the Carteret Club, and closing with a general meeting in the auditorium of St. Peter's College, when Dr. Hilton S. Read gave a report of the Committee on Voluntary Health Insurance (Jour., Feb., 1939, p. 103).

Dr. Morris Fishbein gave an address on "American Medicine and the National Health Program".

President W. J. Carrington gave an address on "Medicine in the News".

Nothing of a controversial or disciplinary nature was brought before the Councilor during the year.

THE THIRD COUNCILOR DISTRICT

By BARCLAY S. FUHRMANN, M.D., Councilor
Flemington, N. J.

To the House of Delegates:

The county medical societies in the Third Councilor District are in an excellent condition. Their programs show that they are acquainted with the problems which are confronting the medical profession at the present time, both from a scientific and an economic standpoint.

On November 17th, 1939, a District Councilor Meeting was held at Princeton, N. J., which proved to be one of profit, as well as of pleasure. The meeting was well attended and the favorable comment expressed demonstrated the value as well as the need for such an occasion. I wish to express my thanks to all who helped make this meeting a success.

THE FOURTH COUNCILOR DISTRICT
Monmouth, Ocean, Burlington and Camden Counties

By JAMES A. FISHER, M.D., Councilor
Asbury Park, N. J.

To the House of Delegates:

No medical-legal matters of grave concern have been called to the attention of the Councilor during the past year in the Fourth District.

During the Winter, a District Meeting was held in Camden County under the direction of Dr. Thomas Lewis, which was attended by a number of Camden County men and a few from each of the other counties composing the district. A most interesting program was presented. A talk was given by the President, Dr. Carrington, and the State Senator and Legislators from Camden County were guests.

THE FIFTH COUNCILOR DISTRICT

Atlantic, Cape May, Cumberland, Gloucester and Salem Counties

By CHESTER I. ULMER, M.D., Councilor
Gibbstown, N. J.

To the House of Delegates:

The Fifth Councilor District meeting was held in Bridgeton on November 15th, 1938, with ninety-two members in attendance. The officers and members of the Cumberland County Medical Society deserve much credit for their efforts in making this meeting a success.

It is interesting to note that two of the societies in the District are having meetings more frequently. This is very desirable. Cumberland County has added several additional monthly meetings during the year, and Cape May has had some several meetings in addition to regular ones. Every county society should plan to have at least nine meetings during the year. By so doing, better interest is maintained, and membership in the Society made more attractive.

The Councilor was called upon for advice in a threatened malpractice suit against two of the members in the District. There is little possibility of this case coming to court.

REPORT OF THE PUBLICATION COMMITTEE

By HENRY C. BARKHORN, M.D., Chairman, Newark, N. J.

To the House of Delegates:

The major function of the Publication Committee is to "Publish and distribute The Journal" (By-Laws, Chapter VIII, Section 7).



The work of the Publication Committee is under the supervision of the Board of Trustees, who "Appoint an Editor and such other assistants as the needs of the Society may require" (By-Laws, Chapter VI, Section 5 b).

The contents of The Journal consist of four divisions:

1. Reports of the officers and committees of the State Society and its component county societies.
2. Scientific papers.
3. Editorial comments on the activities of the Society and those of allied organizations.
4. Advertisements.

THE BUDGET AND EXPENSES

At the beginning of the official year, the Publication Committee is assigned a budget of expenses to which the committee is required to conform. The income from advertising is not used in paying the expenses of The Journal, but is turned into the general fund of the Society. This fact makes it necessary that the reports of the officers and committees as well as the scientific papers, must often be edited and condensed in order that all their essential facts may be printed within the limits of space which is permitted by the budget. However, after each important article and report is edited, it is submitted to the author for his approval before it is published.

EDITORIAL STAFF

The staff of The Journal consists of the Editor, and an Editorial Secretary, and a reporter in each county society. The editorial office is an integral part of the executive offices, and there is a harmonious coöperation between the members of their staffs. The editorial staff receives a great part of the material for The Journal from the executive staff; and in return the records in The Journal are among the most available sources of infor-

mation regarding the past activities of the Society.

PUBLICATION COMMITTEE MEETINGS

Throughout the year the Publication Committee holds monthly meetings at which the contents of The Journal are discussed in detail. All debatable questions are referred to the proper officers of the Society for their final decision. Also, the Editor and the Chairman of the Publication Committee consult the President or the Chairman of the Board of Trustees before making an unusual decision.

TRANSACTIONS OF THE HOUSE OF DELEGATES

The work of publishing the stenotyped minutes of the House of Delegates has always been assigned to the Publication Committee, of which the Secretary of the Society is a member. In 1938 the House of Delegates and the Trustees authorized the Publication Committee to edit the minutes so as to exclude inconsequential items and words, and yet preserve a complete record of each essential action. This was done, with the result of reducing the size of the Transactions to a marked extent, and with a corresponding increase in their conciseness, clearness, and readability. Not a word of complaint regarding this editing has reached the Publication Committee.

The committee therefore requests the House of Delegates to authorize the adoption of this plan during the present year.

LEAVE TO PRINT

The saving of space resulting from editing the minutes of 1938 was counteracted by "Leave to print" several pages of delayed and supplemental reports which were not considered by any Reference Committee, or by the House of Delegates.

The Publication Committee therefore requests the authority to omit from the Transactions all delayed or supplemental reports which were not necessary for conducting the business of the House. This request is made for the sake of economy of space, and therefore of money.

POLICIES

An extensive description of the policies of the Publication Committee, and an analysis of the features of The Journal, were published in the 1938 report. These policies and methods seem to have received the tacit approval of the

members, and will be considered as standards for the committee to follow in the future.

The Publication Committee desires to recognize the personal interest which the printer and the engraver have taken in the mechanical make-up of The Journal. Each has made a free donation of his time and special knowledge in designing the pages of The Journal technically and economically.

CONTENTS OF THE JOURNAL

The accompanying table is an analysis of the contents of The Journal during the year 1938.

1938	Editorial	Original Articles	State Society Activities	Contacts and Com- ments	County Societies	Woman's Auxiliary	Pages of Reading	Pages of Advertising	Total Pages
January	6	35	12	2	7	4	60	34	100
February	8	21	14	2	13	4	62	38	100
March	4	40	8	1	8	3	64	36	100
April	4	36	11	1	9	5	66	34	100
May	4	60	11	1	7	5	88	62	150
June	5	25	24	0	11	3	68	40	108
July	4	24	20	1	7	2	58	34	92
August	4	27	23	1	2	1	58	42	100
September	4	34	25	1	0	0	64	36	100
October	5	24	32	0	2	1	64	36	100
November	4	20	23	2	8	3	60	40	100
December	4	27	19	2	18	0	70	36	106
Totals for 1938	56	373	222	14	92	31	788	+ 468	= 1256
Monthly average	4.66	31.1	18.5	1.16	7.66	2.58	65.66	+ 39	= 104.66
Totals for 1937	66	385	154	27	108	34	774	+ 510	= 1284
Totals for 1936	72	380	173		98	25	746	+ 366	= 1112
Totals for 1935	70	425	143		98	20	756	+ 370	= 1126

NUMBER OF PAGES IN THE JOURNAL OF 1938, BY DEPARTMENTS

A comparison of this table with those of previous years shows a uniformity in the number of pages of the several sections of The Journal. However, this uniformity has been unbalanced by the increase in the activities of the Society since the Annual Meeting on May 17-19, 1938, which has resulted in a considerable increase in the number of pages devoted to State Society activities, and a corresponding decrease in the number of pages of scientific articles; but the former relative sizes of the departments will be restored during the summer season of comparative inactivity.

RESEARCH IN MEDICAL HISTORY

The Editor has frequently been asked by officers and committeemen to trace certain lines of medical activity through the printed minutes of past years. The records show an un-

hurried adoption of every worthy project, and a persistency in following it up and establishing it on a permanent basis.

In order to make the results of these researches available, the House of Delegates authorized their collection and publication (Transactions, 1938, p. 51).

Much of the material which has been collected will be shown in the historical division of the exhibit of the Woman's Auxiliary. The research is going on with increasing impetus, and is including the records of the county societies through their own historical committees.

Receipts from June 1, 1938, to April 15, 1939 (turned over to Dr. Marsh)	\$10,236.15
On hand	209.70
Estimated receipts to May 31, 1939	1,676.00
	<hr/> \$12,121.85

Expenses from June 1, 1938, to April 15, 1939:	
Journal	\$12,349.04
Reprints	112.25
Addressograph	46.26
	<hr/> \$12,507.55
Estimated expenses to May 31, 1939	1,650.00
	<hr/> \$14,157.55

Respectfully submitted,
HENRY C. BARKHORN, *Chairman*
EDWARD JOSEPH ILL
JAMES LAWRENCE EVANS
WILLIAM JOHN CARRINGTON, *Ex-Officio*
ALFRED STAHL, *Ex-Officio*
FRANK OVERTON, *Editor*

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE AND INSURANCE, 1939

By CHRISTOPHER CHARLES BELING, M.D., Chairman, Newark, N. J.

PART ONE—MEDICAL DEFENSE

To the House of Delegates:

During the past year there has been an increase in the number of members insured under the special professional liability contract. The exact figures will not be available until the Annual Meeting.



CLAIMS

There were ninety-four claims during the past year,—the highest number reported since 1921, which was the first year of professional protection under the insurance contract. Most of these claims originated in the more populous counties. Claims have been reported from every county during the past five years.

In a number of the counties the loss ratio was over 100 per cent. It must be borne in mind that a single claim in any one of the smaller counties, where the membership is small, wipes out the income from the annual premiums for many years. This has occurred several times during the past five years. It emphasizes the importance of our *state contract*, since no individual county could carry the contract under the present favorable rates.

KEEPING RATES LOW

Your committee has been informed that there will not be an increase in rates in the immediate future, unless some unforeseen condition compels the company to increase the existing rates. To prevent an increase in the number of claims, the committee coöperated with the insurance company in bringing to the attention of the profession the importance of avoiding the pitfalls which lead to suits. Several county societies were addressed by the Defense Attorney of the company, Mr. William P. Braun; by the chairman of the com-

mittee, and by the official broker. The committee has had to correct wrong impressions made by unauthorized agents to some of the county societies regarding the scope and operation of the Society's plan of Medical Defense.

For the information of all county societies, the committee respectfully submits that any matters pertaining to Medical Defense, presented through extraneous sources, should be referred to the committee before any action is taken.

SUPERVISION OF POLICIES

In previous reports the committee has set forth the importance of an efficient organization in maintaining medical defense. It is important that every member should place his insurance through the official broker so that his interests could be safeguarded. Where the proper supervision has not been exercised through regular channels, the interests of the members have not always been adequately protected. To cite an example, one physician complained to the committee that he had paid for the State Society's policy for two years, although he was not in good standing. This would not have happened if it had been checked up officially. This is a serious matter because, if the doctor was not in good standing, under the terms of the contract he would not be entitled to defense or indemnity.

CO-OPERATION

The committee takes this opportunity to thank the Medical Defense Committees of the component county societies for their coöperation in carrying on this work.

In conclusion, adequate protection of the members against fraudulent claims and malpractice suits cannot be accomplished by our committee alone. Each and every member must subscribe to and support the endeavors of the Society in its work. "To win the day", we must have "close coöperation" and "the teamwork of every bloomin' soul".

PART TWO—ACCIDENT AND HEALTH INSURANCE

The new improved group accident and health policy, developed as the result of the first twelve years of experience with group disability insurance, has been presented to the members. Its acceptance by a larger number of doctors than ever before in the history of group

accident and health disability evidently indicates that the contract has found favor with the members of the Society. There are now 275 policyholders. Forty-one claims were paid during the past year, ranging from \$28.57 to \$1,500.

ARBITRATION CLAUSE

The value of the arbitration clause in the policy was demonstrated last year, when a dispute occurred between a policyholder and the company. A case involving \$1,500.00 was submitted to the committee for arbitration. From its own investigation the company considered the payment of \$750 an adequate compromise settlement, particularly in view of the fact that another insurance company had refused to pay on the same claim. After careful consideration of the evidence in the case, your committee decided in favor of the doctor, giving him the benefit of any doubt. The company accepted the decision, and within twenty-four hours sent the doctor its check for the full amount of his claim. In other instances the company has made prompt settlement of claims.

TERMS OF THE POLICY

The committee has been able to obtain a broadening of the terms of the accident part of the policy. Hereafter weekly indemnity will be payable for a period of four years instead of a period of two years; and in addition to the regular monthly indemnity for the loss of the thumb and forefinger, the dismemberment clause will include a lump sum payment of \$1,250; and also the premium for the accidental death benefit supplement has been reduced in cost.

Your committee considered the proposals of other companies, but found that none of them came up to the standards of the present policy of the National Casualty Company of Detroit.

RATING

As many inquiries have been made by members regarding the financial standing of this company, your committee finds that the Alfred M. Best Company, an outstanding authority on

company ratings, reports that the company has assets of \$4,633,453, against liabilities and reserves of \$2,483,177, leaving an excess or surplus for the further protection of policyholders of \$2,150,276. To state it in other words, the company has assets of \$1.86 for each \$1.00 of liabilities. According to Best & Company, "Sixty-eight per cent of the assets constitute cash and bonds, which amount is in excess of the company's reported liabilities,—a very good liquid position. The average casualty company has approximately 62 per cent of its assets invested in bonds and cash. Stock issues comprise nine per cent of the assets, those of the average company constituting 20 per cent."

The company is given an A plus (excellent) rating.

RECOMMENDATIONS

The committee recommends as follows:

1. The renewal of the professional liability contract for the next year through Faulhaber & Heard, Inc., the official brokers of the Society.

2. The continuation of the Accident and Health Insurance with the National Casualty Company of Detroit, through its representatives, E. and W. Blanksteen of Jersey City, New Jersey.

3. That the county societies be requested by the State Society to endorse the Medical Defense, and the Accident and Health Insurance policies of the State Society, and urge their members to obtain their contracts through sources which are approved by the State Society.

Respectfully submitted,

CHRISTOPHER CHARLES BELING, *Chairman*
JOSEPH WALLACE HURFF, *Vice-Chairman*
JOHN CHARLES MCCOY
GEORGE THOMAS TRACY
WILLIAM CARTER WESCOTT
WELLS PHILLIPS EAGLETON, *Consultant*

REPORT OF THE COMMITTEE ON HONORARY MEMBERSHIP

By LANCELOT ELY, M.D., Chairman, Somerville, N. J.



To the House of Delegates:

The Committee on Honorary Memberships makes the following report:

The Honorary Membership Committee has had conferences through correspondence by mail and to the present date no recommendations for Honorary Membership in the State Society have been received.

Respectfully submitted,

LANCELOT ELY, *Chairman*
EPHRAIM ROLAND MULFORD (deceased)
FREDERIC JAMES QUIGLEY

REPORT OF THE COMMITTEE ON POST-GRADUATE EDUCATION

By DAVID FULLER BENTLEY, M.D., Chairman, Haddonfield, N. J.

To the House of Delegates:

The annual report of the Committee on Post-Graduate Education was anticipated in the announcement of its "Objectives" in The Journal of January, 1939, page 36. This committee suggests that this article be accepted as its annual report and reads as follows:



Your Committee on Post-Graduate Education greatly feels the loss of our Chairman, Dr. Satchwell, and has undertaken

to continue the work which he had so ably promoted, with some misgivings.

THE 1938-1939 COURSES

This year we have continued courses in four centers, namely Camden, Mercer, Salem, Cumberland, and Atlantic Counties with the coöperation of Rutgers University, and the able assistance rendered by Dr. Miller and Dr. Light of the University's Extension Division.

We hope these courses will prove just as beneficial and even more popular than those previously held. The course in Camden has already been completed, and one meeting was held at which there was an attendance of approximately ninety men. Chairmen in the other counties who are members of this committee have expressed hope that the courses will be repeated this year. This would mean that approximately four hundred physicians in the state will be taking courses in Post-Graduate Medicine, under the direction of the Rutgers University Extension Division.

We are contemplating making a survey of the number of men in the State, who as individuals, are taking post-graduate instruction, either in specialties or general medicine. This will probably be done by questionnaire.

SPEAKERS FOR COUNTY SOCIETIES

We have offered the use of the Post-Graduate Committee to any county society in the State who may feel that, through us, some desirable speaker may be obtained for its meetings. Dr. Light of the Rutgers Extension Division has interested himself

in this phase of the work, and feels that any of the members on the post-graduate faculty might be available for this purpose.

The Executive Office in Trenton keeps a file regarding courses of instruction that are available in New Jersey and in other states, particularly information and announcements coming to it through the American Medical Association. This information will be available to any member who requests it from the Executive Officer, 143 East State Street, Trenton, N. J.

The post-graduate work in the upper part of the State, we understand, will be undertaken by the local county societies; and while no official notice has been sent the committee, we have learned that clinics and lectures are contemplated in Hudson, Essex, and possibly some of the other counties.

THE FALL CLINICAL CONFERENCE

The committee was greatly impressed by the success of the first clinical conference which was held in Newark this Fall, and feels that every effort should be made to continue these meetings and to broaden their scope. We realize the importance of placing post-graduate programs before our membership, and regret that the facilities offered are not utilized by many more of our members.

PUBLIC HEALTH SUBJECTS

We have coöperated with the Committee on Public Health, and one of our members regularly attends its meetings so as to keep us in touch with its activities. We are endeavoring to introduce subjects which pertain to public health, and thus assist somewhat the Public Health Committee's program.

We have endeavored to exemplify the standards expressed by President Carrington—that every member of the New Jersey Medical Society undertake to secure for himself some post-graduate instruction each year;—but in addition to the lectures and courses sponsored directly by the committee, each county society makes scientific instruction a prominent feature of its program of nearly every meeting.

Respectfully submitted,

DAVID FULLER BENTLEY, *Chairman*
STUART ZEH HAWKES, *Vice-Chairman*
ALBERT WILLIAM FIGOTT
ERNEST FRANCIS PURCELL
HAMMELL PIERCE SHIPPS
SLOAN GRIFFIN STEWART
CLARENCE WILTON WAY
HARRY ROSS NORTH, *Consultant*

REPORT OF THE COMMITTEE ON VOLUNTARY HEALTH INSURANCE

By ELTON WALLACE LANCE, M.D., Chairman, Rahway, N. J.

To the House of Delegates:

Efforts to develop a plan for the distribution of medical care to persons in the low-wage group started in October, 1939.

The first committee, a fact-finding committee, under the chairmanship of Dr. Hilton S. Read, reported in December, 1938, to the effect that some form of voluntary health insur-

ance can be evolved which is adaptable to the needs of the people of New Jersey. (See the Journal of February, 1939, page 103.)

The study was continued by a "Committee on Voluntary Health Insurance", under the chairmanship of Dr. Edward W. Sprague. In February, 1939, this committee reported, stating the fundamental principles upon which it believed any plan should be formed. The committee recommended that a "Founding Committee" be appointed to continue the study, and to form a plan for presentation to the Trustees. (Journal of March, 1937, page 165.)

The present committee, under the chairmanship of Dr. E. W. Lance, has continued the study of the general subject, and investigated the progress of the committees of other States who are working on the same subject. For this purpose a delegation from the committee visited Washington, D. C., to study the "Mutual Health Service", a plan evolved and initiated

by The Medical Society of the District of Columbia.

On April 16th, 1939, Dr. J. A. Hannah, Medical Director of the Associated Services Incorporated, of Toronto, Canada, addressed the Welfare Committee on the organization and administration of such a plan, and spent the rest of the day in consultation with this committee. (See report of the Welfare Committee meeting in this Journal.)

The committee is now (April 20) ready to take more definite steps toward the formulation of a plan to be presented to the House of Delegates.

Respectfully submitted,

ELTON W. LANCE, *Chairman*
EDWARD SPRAGUE
JAMES F. NORTON
FRANCIS H. TODD
MAX L. WEIMANN
WILLIAM G. HERRMAN
J. ALLEN YAGER
LESLIE E. MYATT
NORMAN N. FORNEY
AUGUSTUS S. KNIGHT
H. L. HARLEY

REPORT OF THE COMMITTEE ON EUGENIC STERILIZATION

By CHARLES WRIGHT MACMILLAN, M.D., Chairman, Passaic, N. J.

To the House of Delegates:

The Committee for the Study of Sterilization, which was appointed to consider the evidence for the prevention of procreation of the unfit, presents the following summary of a detailed paper submitted by T. R. Robie, M.D., entitled "The Conservation of Intelligence". This paper contains three lines of argument:

1. That feeble-mindedness is one of the most common causes of ignorance, unemployment, indigency, and crime; and other unsocial conditions and acts.

2. That heredity is the predominant cause of feeble-mindedness.

3. That the prevention of procreation of those of low intelligence is the most satisfactory and efficient method of dealing with the conditions arising from a deficiency of mental capacity.

The committee has come to the conclusion that the presentation of its findings along these three lines is a necessary preliminary to the

consideration of specific means of preventing the procreation of the mentally unfit. This procedure follows the usual method of making a *diagnosis* before adopting any method of *treatment*. The committee has therefore prepared a comprehensive brief, setting forth the evidence in support of the control of procreation of the feeble-minded. The report itself is necessarily rather voluminous, and will be placed on file in the Executive Offices, where it may be consulted by any physician who desires information on any phase of the subject. The subdivisions of the report are summarized in the following abstract:

RATIONAL POPULATION CONTROL

Population control is the greatest international problem of the day. Certain portions of our population should not be permitted to reproduce.

The population of New Jersey increased 28 per cent from 1920 to 1935. In the same period the inmates of State institutions for the feeble-minded, the State hospitals for the insane, and the wards of the State Board of Children's Guardians increased 250 to 400 per cent. With this decrease in mental efficiency there will come an enormous increase in the cost of trying to educate the growing proportions of those mentally deficient.



THE UNREFORMABLE

Reliable reports demonstrate the failure of persons and reformatories to rehabilitate the feeble-minded criminal. We cannot expect the correctional institutions to reform those incapable of reformation.

CRIME

The feeble-minded constitute two or three per cent of the general population, while in the prison population they constitute 27 per cent of the inmates.

RELIEF

The birth rate of families on relief is from 50 to 60 per cent higher than among similar families not on relief. When the great mass of self-supporting families are limiting their size because of the expense of raising a family properly, will they consent indefinitely to an unlimited multiplication among those maintained at public expense?

UNEMPLOYMENT

The majority of the unemployed fall in the lower *intelligence quotient* groups. As intelligence levels fall, the chances of being unemployed increase rapidly. In general, the intelligence quotient of the children of a given family will correspond closely to the average of that of the two parents.

Since the employment of a large number of low-grade workers depends on the presence of a proportion of higher grade workers, a deficiency of numbers in the higher grades will necessarily result in a proportional decrease of employment in the lower grades.

It is self-evident that the feeble-minded are practically uneducable; yet while the appropriations for education in New Jersey have been reduced 20 per cent, those for institutions and agencies are constantly being increased. The cost of educating a mentally retarded child in Newark is over twice that of a normal child. But no amount of education will ever make a genius out of a moron.

ECONOMICS

The expenditures for custodial care of the feeble-minded are constantly increasing at an enormous rate, and will continue to increase unless active steps are taken to decrease the moron output. We have heard much concerning *crop* control, but only a little concerning intelligent *population* control.

PROGRESSIVE CALIFORNIA

Laws permitting selective sterilization have been enacted in thirty States, and 25,878 sterilizations had been done in the entire country up to January 1, 1939; of these more than one-half have been done in California. This is only a beginning, since estimates number the feeble-minded well over 3,000,000. Unfortunately, feeble-minded persons possess insufficient judgment to carry out voluntarily any prescribed method for the control of procreation. Therefore, permanent sterilization is the only sure means of preventing their rapid rate of reproduction.

Detailed descriptions of operations now in use for both the male and female have been published in medical journals. An especially comprehensive article, "Sterilization Without Unsexing", by Robert L. Dickinson, M.D., appeared in the Journal of the A. M. A. February 2, 1929.

In many of the States in which sterilization laws are in force, the State Medical Societies were among the organizations which demanded the enactment of the laws. The Committee of The Medical Society of New Jersey for the Study of Selective Sterilization wishes to help the members to become adequately informed in this field, so that the Society will join with the imposing list of organizations which already endorse a law to improve the standard of citizenship in the Commonwealth. Medical science cannot lag behind lay organizations in this matter if it is to maintain its supremacy in the field of preventive medicine.

Respectfully submitted,

CHARLES WRIGHT MACMILLAN, *Chairman*
SAMUEL EMLIN STOKES, *Vice-Chairman*
WALTER JOHN FARR
THEODORE RUSSELL ROBIE
ALFRED FREDERICK SFERRA (deceased)
SAMUEL ALEXANDER, *Consultant*

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

By ANDREW F. McBRIDE, M.D., Paterson, N. J.

To the House of Delegates:

The American Medical Association held two sessions during the year 1938.

The first session was the regular annual meeting and was attended by Drs. Conaway, McBride, Read, and Snedecor. A report of each of these delegates was printed in The Journal of July, 1938, pages 439-444.

The second meeting of the A. M. A. was a special session held on September 16 and 17, 1938. New Jersey was represented by four

delegates and six observers—Drs. W. P. Eagleton, E. R. Mulford, H. S. Read, A. F. McBride, W. J. Carrington, T. K. Lewis, Alfred Stahl, S. T. Snedecor, L. A. Wilkes, and Walt P. Conaway. Reports from each of these delegates and observers were printed in The Journal of October, 1938, pages 614-626.

Respectfully submitted,

WALT P. CONAWAY
ANDREW F. McBRIDE
E. R. MULFORD (deceased)
WELLS P. EAGLETON
HILTON S. READ

REPORT OF THE COMMITTEE ON THE ANNUAL MEETING

By CHARLES BUTCHER KAIGHN, M.D., Chairman, Atlantic City, N. J.

To the House of Delegates:

The Committee on the Annual Meeting is charged with the duty of making arrangements for the accommodations of all the various departments and sections of the annual meeting, and of providing facilities for the clerical staff. It has been in continuous contact with the President and with the other officers and committees, and has been of essential service to



them in coordinating their times and places of meetings.

A sub-committee on the Scientific Program has prepared a program for the general scientific session; and a sub-committee on Scientific Exhibits has assigned the booths to the exhibitors.

So far as possible, every contingency has been anticipated, and all preparations are well advanced to accomplish the objectives set forth in The Journal of April, page 237.

Respectfully submitted,

CHARLES BUTCHER KAIGHN, *Chairman*
CLARENCE LADELLE ANDREWS
ASHER YAGUDA
THOMAS McGRATH BRENNOCK
JOHN CLIFFORD CLARK
WILLIAM JOHN CARRINGTON, *Consultant*

REPORT OF THE SUB-COMMITTEE ON SCIENTIFIC PROGRAM

By CLARENCE LADELLE ANDREWS, M.D., Chairman, Atlantic City, N. J.

To the Committee on the Annual Meeting:

The arrangement of the scientific program of the Annual Meeting is the primary function of this committee. A complete program has been provided, and is published in this Journal.



Respectfully submitted,

CLARENCE LADELLE ANDREWS, *Chairman*
ROBERT SPEER GAMON, *Vice-Chairman*
LOUIS CHARLES LANGE
HARRISON STANFORD MARTLAND
PAUL BRYSON REISINGER
WILLIAM JOHN CARRINGTON, *Consultant*

REPORT OF SUB-COMMITTEE ON SCIENTIFIC EXHIBITS

By ASHER YAGUDA, M.D., Chairman, Newark, N. J.

To the Committee on the Annual Meeting:

The *Committee on Scientific Exhibits* anticipates a most successful Scientific Exhibit for the Annual Convention for 1939. About fifty separate exhibits will be presented. These exhibits will cover a wide field of scientific activity, and the quality should surpass anything we have had previously.



It has been the policy of this committee to encourage local exhibitors, and this year we are pleased to announce a greater interest on the part of New Jersey physicians. Although

the majority of the exhibits will be presented by New Jersey physicians, nevertheless the committee has had space available for a select number of out-of-state exhibitors. Among these will be exhibits from the Mayo Clinic, and from medical colleges of New York and Philadelphia.

As in previous years, the committee will continue the presentation of fresh pathology exhibit, and will provide a motion picture theater for scientific films. The committee also will continue the distribution of two classes of awards as in previous years.

Respectfully submitted,

ASHER YAGUDA, *Chairman*
JAMES GORDON BOYES, *Vice-Chairman*
NICHOLAS MARK ALTER
WILLIAM WOLF HERSOHN
LUTHER AUGUSTUS MARKLEY
HARRY ROSS NORTH, *Consultant*

REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

By JAMES FRANCIS NORTON, M.D., Chairman, Jersey City, N. J.

To the House of Delegates:

The Committee on Constitution and By-Laws has not received any proposals of new amendments, and has none to offer on its own initiative. However, two amendments to the Constitution, which were passed in 1938, will come up for a final vote this year—one relating to appeals from the *Judicial Council*, and the other that councilors may be elected from among the *membership*. (Jour., Feb., p. 118.)



Respectfully submitted,

JAMES FRANCIS NORTON, *Chairman*
DAVID KRAKER, *Vice-Chairman*
HERBERT WILLIAM NAFEY
GEORGE N. J. SOMMER
DAVID H. BARTINE ULMER
FREDERIC JAMES QUIGLEY, *Consultant*

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

By GUSTAV AUGUST BRAUN, M.D., Chairman, Newark, N. J.

To the House of Delegates:

The Advisory Committee to the Woman's Auxiliary has tried to act in its true capacity of being wholly *advisory* in character.

The program and plans of the Woman's Auxiliary have been thoroughly studied, and particular emphasis placed on the subject of Arts, History and Hobbies.



There has been the fullest coöperation between the committee and the State Auxiliary.

Arrangements for a suggested definite budget to make the Auxiliary function were approved and adopted.

Respectfully submitted,

GUSTAV AUGUST BRAUN, *Chairman*
WILLIAM KING CAMPBELL, *Vice-Chairman*
LOUIS FEINSTEIN
GERALD ELLSWORTH McDONNEL
JOSEPH ROWLETT MORROW
ALDRICH CLEMENTS CROWE, *Consultant*

PART TWO

EXTERNAL RELATIONS

CENTERING IN THE WELFARE COMMITTEE

with Its

FOUR SUB-COMMITTEES

and

EIGHTEEN ADVISORY COMMITTEES

REPORT OF THE WELFARE COMMITTEE

By HILTON SHREVE READ, M.D., Chairman, Ventnor, N. J.

To the House of Delegates:

The Welfare Committee held all its scheduled meetings, and discussed the various proposals brought to it by the Advisory Committees, the Trustees, and the component county societies. The attendance was larger than ever before, due to the concentration of committee meetings held on the same day. The close association of the members on these occasions, especially the opportunity at luncheon for personal contact, had a good effect in furthering an esprit de corps, and an interchange of ideas and opinion.



TIMES AND PLACES OF MEETING

Due to the prolonged full-day meeting and the expense involved, it has been suggested that the Advisory Committees might meet at various convenient centers and discuss their special problems more fully in the interim *between* the meetings of the Welfare Committee, and then submit their specific recommendations to the appropriate sub-committee of the Welfare Committee for consideration by the sub-committee at meetings held prior to the Welfare Committee and on the same day if this be considered advisable, so that these committee reports can be embodied into a single report approved by the sub-committees and be then placed before the Welfare Committee for final action.

There was a feeling among some of the Trustees that they might better meet on a separate day rather than attend part of the Welfare meeting since their meeting was late in getting under way and the members could not get home as early as formerly if the program was a lengthy one. They felt also that their withdrawal disturbed the Welfare Committee members, though no comment to this effect was voiced to the Chairman by the Welfare Committee members. Your Chairman believes these suggestions to be desirable, but the combined meetings this year served a very useful purpose and justified the experiment.

PROCEDURES AT THE WELFARE COMMITTEE

The topics discussed, and the decisions reached were many and varied, and every effort was made to avoid unnecessary loss of time. The Chairman offers his apologies to any of the members who may have felt unduly limited as to time, and offers the explanation that his sole purpose was to dispatch the agenda within the allotted time.

Your Chairman expresses his personal thanks for the time given and the interest shown by each member of the Welfare Committee, and hopes that the Society members will feel that the committee members' efforts and general recommendations merit approval and support, and that the results achieved in the component county medical societies will justify the time and effort involved.

The several reports of the sub-committees, and their advisory committees are printed separately in *The Journal*, and each county society or individual member may appear by appointment before any Reference Committee at the announced time of its meeting, as shown

in the schedule of meetings in the program, in order to present suggestions or criticisms. The Reference Committee will consider all points that are brought to its attention, and will make its final recommendations to the House

of Delegates on the last day of the Annual Meeting.

Respectfully submitted,
HILTON S. READ, *Chairman.*

A list of the sixty-seven members of the committee is printed in each issue of The Journal.

REPORT OF THE SUB-COMMITTEE ON LEGISLATION

By BERTHOLD STEINBACH POLLAK, M.D., Chairman, Jersey City, N. J.

To the Welfare Committee:

Our cheeks are still aglow because of the victory which has come to our cause by reason of the passage of Assembly Bill 210 by a vote of 38 to 16. In contemplating these results we are not unmindful of the tremendous effort that was expended in time and money, and particularly the personal sacrifices of a few loyal and enthusiastic supporters that have made this accomplishment apparently a reality. But at the very moment of writing this report, which has been purposely held up until this day (April 20th) so that we might transmit to you the very latest news, we find that, whilst we were rejoicing over our initial efforts, on this very same evening the Judiciary Committee in the Senate had reported favorably on Senate Bill 205—known as the Chiropractor's Bill,—which provides for a separate Board of Chiropractors, which would vitiate the provisions of our Uniform Practice Act.

It thus becomes apparent that a more united and concentrated effort must be put forth by organized medicine. In order that our cause may be fully comprehended, the respective units of our Society,—to wit, the county medical societies,—must energetically coöperate with the Legislative Committee of The Medical Society of New Jersey so that the interests of the public as well as the profession may be conserved.

We have from time to time emphasized our position by the statement that legislation must be secured at home by the intelligent interpretation of our key men and the officials of our respective county medical societies if our ideals, our concepts and aspirations are to prevail. Furthermore, it must be apparent to the entire membership of our State Medical Society that the preparation of our Uniform Practice Act

has been in progress for a period of almost five years; and that in spite of the tremendous efforts which we have expended in that direction, and in spite of some outstanding support that has come to us from understanding members of the Assembly as well as the Senate, we have as yet not succeeded in impressing the majority of the legislators with the verity that our cause is just, and one that is primarily of interest to the public at large.

It thus becomes obvious that we must seriously reflect upon our future course of action. We cannot hope to achieve success until our membership at large will recognize their individual responsibility and will be prepared to render service when service is called for by those of us who from time to time may be honored by you in directing the legislation appertaining to the welfare of the public as well as our profession.

We cannot help but to acknowledge the sacrifices and coöperation that we have received from the officials of the State Society, our President, our President-Elect, and Dr. Wilkes—they have rendered outstanding service. To Dr. Quigley and Dr. Alexander we hereby desire to particularly express our appreciation, for they have most unselfishly and without stint materially aided us in every effort.

A final list of legislative bills considered by this committee and marked "approved" or "disapproved" will be submitted to the House of Delegates at the Annual Meeting as the Legislature is still in session.

Finally, our committee desires to acknowledge the splendid and efficacious work of the Committee on Public Relations under the very competent leadership of Dr. Kler; and we would respectfully recommend that the services of that able committee be amalgamated with the Legislative Committee, to the end that the best interests of our profession may be conserved by these united efforts.

All of which is respectfully submitted by:

The Committee on Legislation,
BERTHOLD STEINBACH POLLAK, *Chairman*
CHARLES HENRY MITCHELL, *Vice-Chairman*
WENDALL JONES BURKETT
HERBERT ROY VAN NESS
WILLIAM CRANE WILENTZ
SAMUEL ALEXANDER, *Consultant*



THE SUB-COMMITTEE ON MEDICAL PRACTICE AND ITS EIGHT ADVISORY COMMITTEES

REPORT OF THE SUB-COMMITTEE ON MEDICAL PRACTICE

By DAVID BACHARACH ALLMAN, M.D., Chairman, Atlantic City, N. J.

To the Welfare Committee:



The Sub-Committee on Medical Practice consists of the chairmen of the eight advisory committees, whose reports are submitted herewith.

We feel that, working in harmony during the year, and holding the objectives of the administration in

mind, we have advanced far along the road towards a better understanding of our various problems, to the decided advantage of organized medicine.

This sub-committee has had many successful meetings, most of which had 100 per cent attendance. Although some were long and the work tedious, we feel that the results accomplished, as shown in the following reports of the advisory committees, amply repay us for the time and energy that has been expended.

The Advisory Committee on Auxiliary Medical Service had for its objectives the promotion of public health by extending auxiliary medical services, including x-ray, laboratory, anesthesia, and physiotherapeutic measures; the preservation of private practice; and the

study of hospital practices throughout the State.

The following report of Dr. William Wallace Maver, chairman of that committee, shows how well the work of this committee has been carried on.

REPORT OF THE ADVISORY COMMITTEE ON AUXILIARY MEDICAL SERVICES

By WILLIAM WALLACE MAVER, M.D., Chairman, Jersey City, N. J.

To the Sub-Committee on Medical Practice:

The Advisory Committee on Auxiliary Medical Services was appointed in 1937. Its first report to the House of Delegates, made in 1938 (Jour., May, 1938, p. 302) was brief, and preliminary, but a more extensive supplementary report was made to the House of Delegates and was printed in the Transactions of 1938, pages 16-22. This supplementary report dealt with the broad principles of the relations of hospitals to the four auxiliary services:

1. The Laboratory, pathological and clinical.
2. Radiology.
3. Anesthesia.
4. Physical Therapy.



These reports should be considered as preliminary to the more detailed report that is herewith presented.

OBJECTIVES

The objectives that have been set before the Committee on Auxiliary Medical Services for the years 1938 and 1939 were as follows:

1. Promote public health by extending auxiliary medical services, including x-ray, laboratory, anaesthesia, and physical therapy measures.
2. Preserve private practice.
3. Study hospital practices throughout the State, and recommend remedial measures where they are needed.

The committee has felt that the accomplishment of the first objective could best be attained by collaboration with the organized groups of specialists in the State. To this end, the *New Jersey Society of Clinical Pathologists* and the *Radiological Society of New Jersey* appointed committees to determine the most practical means of extending auxiliary medical services.

It was believed that these services could more readily be brought within the reach of the low-income group by a reduction in the cost of present-day examinations.

Communications which are reprinted herewith have been received from these two society committees, and express the willingness of these groups of specialists to cooperate to the fullest extent with the members of the medical profession in order that these services may be made available to those patients who come within the low-income group.

The committees representing these societies also emphasize the fact that the specialists composing these groups have at all times been willing to cooperate with the medical profession, and wish to bring this fact before the members of The Medical Society of New Jersey. It is recommended, therefore, by your committee that their statements be given adequate publicity in the State Journal, in order that all of the members of the State Society may be advised of these facts. (See addendums numbers one and two.)

It has been the consensus of the members of the Auxiliary Medical Services Committee that this type of cooperation between the specialists and clinicians would encourage private practitioners to use the facilities of the specialists in their practice, and offset the tendency of a certain percentage of deserving low-income patients to go to the general hospitals for medical services of these types.

Inasmuch as there is no organized body of anaesthetists and physical therapists in this State, it is not possible to obtain a statement from these groups of specialists. Those that have been contacted, however, have expressed willingness to cooperate whenever called upon to do so. If this objective is accomplished, it will help to preserve private practice, which is the second objective toward which this committee has been striving.

The third objective, relating to hospital practices in the State of New Jersey, has been under consideration by this committee during 1937 and 1938. This committee believes that the inclusion of medical services in hospital insurance plans is a practice requiring prompt correction. We, as a committee, have not devoted special attention to this matter during the past year, having been advised that the problem was being studied by other committees in conjunction with the problem of *medical cost insurance*.

From information that has been received, it has been noted that there is an increasing tendency throughout the country to eliminate medical services from newly contracted hospital insurance plans. We regret to note that our

State is still among those in the list that continue to accept hospital insurance plans which include medical services. Our committee feels that a more aggressive attitude should be adopted by appropriate groups within the State Society in order that a vigorous demand may be made by the State Society which will cause these medical services to be cancelled from all future contracts that are issued in the State of New Jersey.

During the past year, groups within this committee have completed the answers to the Hospital Questionnaire which was received in the early part of 1938. The answers to the questions that have been tabulated are interesting, and relate to information received from *fifty-four* (54) hospitals in the State of New Jersey. For example, it has been shown:

That forty (40) hospitals are members of the Hospital Service Plan; and that thirteen (13) have not adopted the plan.

That the total bed space in these fifty-four hospitals is 10,446, or an average of 193 beds per hospital, with an average occupancy of 139 per hospital.

That thirty-three (33) hospitals are approved for internship, while twenty-one (21) hospitals of this group are not approved.

The detailed answers to these questionnaires regarding hospital relationships to Auxiliary Medical Services are tabulated and filed in the Executive Offices of the State Society for the use of the membership, but summaries of the findings are included in this report.

This committee is of the opinion that its duties as a fact-finding committee should include a study of commercial laboratories operating in the State. These laboratories exist because they are supported by the medical profession. It is our present impression that their fees are not less than those of the office conducted by the recognized specialist. How much *fee splitting* enters into the life-blood of the commercial laboratory is a question requiring tactful investigation.

The Auxiliary Medical Services Committee acknowledges with thanks the willing cooperation that it has received at all times from the officers of the State Society, the members of the Medical Practice Committee, and our consultant, Dr. Alfred Stahl, whose suggestions and discussions at our meetings have been both helpful and stimulating.

Respectfully submitted,

WILLIAM WALLACE MAVER, *Chairman*
SAMUEL BARBASH, *Vice-Chairman*
ARTURO RAYMOND CASILLI
EUGENE GARFIELD HERBENER
SIGURD WALTER JOHNSEN
JEROME HOWARD SAMUEL
WALTER ALBERT TAYLOR
ALFRED STAHL, *Consultant*

ADDENDUM NO. 1

RESPONSE OF THE NEW JERSEY RADIOLOGICAL SOCIETY, FEBRUARY 8, 1939

In response to your communications to the New Jersey Roentgenologists, a resolution was passed at the recent midwinter meeting of the New Jersey Radiological Society held in Newark, February 4, 1939, authorizing a special committee to communicate with you as to the willingness of the members of the Radiological Society of New Jersey to reduce their fees for services to the low-wage group in order that the necessary roentgenological services will not be denied worthy patients.

It was the sense of this society and, in fact, was drawn to the attention of the members at this meeting that it is considered unethical by the American Medical Association and the National Radiological Societies to publish a list of fees. This applies to

those working in all of the specialties as well as radiology.

The members of the Radiological Society desire to express their willingness to reduce the fees, if necessary to a cost basis or even less, in supplying services for those in the low-wage group or charity cases, but only upon the request of the attending physician.

The roentgenologists also wish to remind the members of the State Society that they have always been willing to cooperate with other medical men in supplying services for those in this low-income group or charity cases, as for example during the period of the Emergency Relief Administration, generally known as the E. R. A.

C. F. BAKER, M.D.

ADDENDUM NO. 2

RESPONSE OF THE NEW JERSEY SOCIETY OF PATHOLOGISTS

An opinion, by written questionnaire, sought from the New Jersey Society of Pathologists on what reduction in the current fees of laboratory examinations could be made to reduce economic pressure on patients of the middle social bracket shows that:

1. The laboratory fees in this State are comparable to the average throughout the country, and in some respects even below the average.

2. The ethical clinical pathologist, like all other physicians, is always willing to adjust his fees to the resources of the patient, and has never hesitated to cooperate with the family physician in reducing fees to the deserving patient of any social class.

3. When laboratory costs seem out of proportion in a particular case, the reason may usually be due either to:

a. Indiscriminate and unnecessary laboratory examinations requested of the clinical pathologist by the family physician.

b. Splitting of fees by the unethical family physician with the unethical laboratory.

RECOMMENDATIONS

1. That, whenever possible, the family physician should refer his patients to qualified laboratories directed by a physician specializing in pathology.

2. That the physician consult the pathologist about contemplated laboratory work required for a given clinical problem.

3. That the physician request of the pathologist a reduction of fee when patient is not able to afford the full amount.

4. That fee splitting should be abolished not only because it lowers medical ethics, but also because it adds unnecessary expense to the patient.

5. That proper and more rigid regulations be made by the State Board of Health or State Society, or both, to license only efficient and adequately equipped laboratories.

6. That the facts above enumerated, and recommendations made, be sent by the State Society to every member of The Medical Society of New Jersey.

ARTURO R. CASILLI, M.D.

The Advisory Committee on Contract Practice has gathered information concerning contract practice in New Jersey. Working with, and through, the component county societies, it has studied industrial practices, school phy-

sicians, compensation practice, and lodge doctors. A statement of their conclusions is set forth in the following report from Dr. Reuben Lore Sharp, who was chairman of that committee:

REPORT OF COMMITTEE ON CONTRACT PRACTICE

By REUBEN LORE SHARP, M.D., Chairman, Camden, N. J.

To the Sub-Committee on Medical Practice:

The *Contract Practice Committee* does not wish to recommend any more specific regulations governing contract practice in the State than as already outlined in the Code of Ethics of the American Medical Association, and as adopted by the House of Delegates of the State Society last year.



COUNTY COMMITTEE

We do, however, recommend the establishment of a Contract Practice Committee in each county whose function shall be:

1. To inspect any or all contracts entered into by its members.
2. To pass upon the merits of such contracts, and decide as to whether they are ethical in relation to medical practice as established in that county.
3. To determine the method of securing

such contracts (i. e., to avoid underbidding).

4. To make such suggestions to its members personally as may be advisable.

We would suggest that the proceedings of the committee be made confidential, except where the offending member proves recalcitrant to suggestions, or where the question of ethics is involved.

In the event of a breach of ethics, or if a member sees fit to ignore the suggestions of the committee, the same course shall be followed as in any other breach of ethics.

We would further recommend that the committee be self-perpetuating, i. e., not entirely new each year; and that its membership be composed preferably of physicians who have previously held some position of trust in the county society.

Respectfully submitted,

REUBEN LORE SHARP, *Chairman*
L. SAMUEL SICA, *Vice-Chairman*
FRANK WILLIAM ASH
JOHN GEORGE DECKER
HENRY HAYWOOD
HARVEY THEODORE HEROLD
EDWARD FREDERICK KLEIN
ANDREW C. RUOFF
JENNINGS HOWARD HORNBERGER, *Consultant*

The Advisory Committee on Hospital Relationships, Dr. S. T. Snedecor, Chairman, has made a comprehensive survey of administra-

tive methods of the hospitals of New Jersey, and states its conclusions in the following report:

REPORT OF THE COMMITTEE ON HOSPITAL RELATIONSHIPS

By SPENCER TREADWELL SNEDECOR, M.D., Chairman, Hackensack, N. J.

To the Sub-Committee on Medical Practice:

The principal work of the Committee on Hospital Relationships during the past year has been to complete the survey of the hospitals of the State which was begun three years ago. A great deal of the early work was carried on by Dr. T. K. Lewis. Progress reports on the work were printed in *The Journal* of April, 1937, page 272; and May, 1938, page 298.



This year Dr. Henry Decker, of Camden,

continued the compilation of data, and the final report has been arranged by Dr. N. M. Scott of the Executive Offices in Trenton. This report was in the form of a survey which will be made available and distributed to hospital executives and members of boards of trustees as well as to members of the Society. It contains evidence of gross defects in the relationship between hospitals and doctors, and makes a number of very definite recommendations for their correction.

It is the opinion of the committee that the recommendations contained in this survey should form a basis for continuation of the association with the hospitals during the coming year.

It is also the hope of the committee that

meetings of the medical staffs with the boards of trustees of the hospitals will be held during the present year. Several of these have already been held, and they should be continued in order to discuss the recommendations of the survey.

Respectfully submitted,

SPENCER TREADWELL SNEDECOR, *Chairman*
WILLIAM H. A. WARNER, *Vice-Chairman*
HENRY BRISTOL DECKER
FLORENTINE MILTON HOFFMAN
CHARLES HYMAN
ELTON WALLACE LANCE
GEORGE O'HANLON
THOMAS KRAPPEN LEWIS, *Consultant*

The Advisory Committee on Industrial Injuries and Occupational Diseases was a new committee, appointed to study industrial injuries and occupational diseases in New Jersey and to recommend measures to protect our

citizens of all economic levels with the preservation of private practice always in mind.

The report, which follows, of Dr. Jacob I. Fort, the chairman of that committee, clearly demonstrates how well this committee has functioned during the past year.

REPORT OF THE COMMITTEE ON INDUSTRIAL INJURIES AND OCCUPATIONAL DISEASES

By J. IRVING FORT, M.D., Chairman, Newark, N. J.

To the Sub-Committee on Medical Practice:

In the formation of the committee plan for advancing and carrying on the work of The Medical Society of New Jersey for the past year, a new committee was formed to study the broad subject of Industrial Injuries and Occupational Diseases. This committee's function was that of a fact-finding search into the conditions among employees of the numerous industries of the State, with special reference to health and hygiene.



OBJECTIVES AND METHODS

As this committee was a new one, there was no available data from previous research or report by the State Medical Society. It was therefore necessary for us to start from the beginning, and to direct our efforts to obtaining information on which to base conclusions. With this idea in mind we decided on our objectives, and on the methods to be used in obtaining our information.

First—We studied the present machinery established in the State for the care and treatment of injuries, and the regulations in force for their prevention.

Second—We attempted to learn, from a

questionnaire, of the prevalence of accidents, the most common and frequent type of injury, and the facilities for the treatment of such injuries. In a like manner, we endeavored to gain some information as to the incidence of occupational diseases, both those compensable and those non-compensable but acquired through the hazards of peculiar occupation.

Third—We considered the medical set-up in industry for the care and treatment of occupational injuries and diseases, and the customary methods of providing such care.

Fourth—Attempt was made to ascertain the number of industries in which preemployment examination is in force; and how extensive and complete is this examination.

Fifth—We took into consideration the number of industrial plants which maintain a medical research department whose function is to study the causation of injuries and diseases peculiar to their type of industry, and to take steps for the prevention and cure of such conditions.

OCCUPATIONAL HAZARDS

Data was obtained through a questionnaire, by personal contact, by a study of statistics from Public Health Bulletins and Issues, and from reports of the Department of Labor of New Jersey.

In the State of New Jersey there are about 700,000 employees in manufacturing, mechanical, and mineral industries. Such industries include auto manufacturing, building, chemical, textile, clothing, food, iron and steel, metals other than iron and steel, rubber, tobacco,

leather, etc., and in addition coal, oil and mining. It is evident that with this wide variety of endeavor there is exposure of employees to many different types of accidental injury and occupational disease. There are the hazards of chemical irritants, gases, dust, etc., productive of disease, and the hazards of injury from the constant use of intricate and complex machinery.

These conditions were early recognized by our Department of Labor, and they therefore set up certain codes for each peculiar industry for the purpose of prevention of accident and disease by safety measures. These codes and regulations are well enforced by constant inspection by a special department or sub-department of the Department of Labor, under the supervision of a Deputy Commissioner.

As a further measure of watching the welfare of the employee, the Compensation Act has been modified and enlarged to include certain occupational diseases. These are anthrax; lead, mercury arsenic, and phosphorous poisoning; poisoning from benzene, wood alcohol and chrome; cassion disease; and the effects of radium.

In spite of these excellent regulations we find that in addition to these compensable diseases there are a large number of conditions which arise from occupational hazards that are in need of study, prevention and adequate treatment. Many of these conditions are skin manifestations from irritants of a chemical nature, or from dust inhalations. The dermatoses are especially liable to occur in employees who are individually sensitive to such irritants. It is also a fact that many of these lesions both of skin and pulmonary tract are difficult to diagnose by the average methods.

MEDICAL CARE

We find that, for the greater part, the larger industrial plants are covered by adequate medical and surgical care by full or part-time physicians. A number of these same organizations have well-equipped research departments where all of the peculiar conditions due to the hazards of the respective industry are studied from both the standpoint of prevention of accident and disease, and that of cure when they occur. In smaller plants the medical set-up consists of a physician or physicians who either visit the plant, or to whose office employees in need of care are sent.

In smaller industries, as a rule the employee receives first aid, and is then sent to a hospital or to his own physician. It is evident, therefore, that the medical profession is doing an excellent work in the care and treatment of injury and disease occurring in industry, and

in aiding the employer to safeguard his employees by preventative measures.

CONSTITUTIONAL CONDITIONS

There is, however, one field which to a considerable degree has been somewhat overlooked, not by the physician, but by the exponents of prevention. This is the employment of certain individuals who are in part physically unfit because of cardio-vascular, pulmonary and renal disease, and certain other diseases and deformities which are not per se industrial diseases. These conditions are such that one suffering from one or more of them is capable of performing only those types of work which their physical make-up permits. If they are placed in occupations beyond their physical ability, aggravation or acceleration of the constitutional disease occurs, and both employee and employer suffer thereby.

There is perhaps another consideration to note which in no way reflects on the medical profession. Owing to the complicated chemical products of this age there are many conditions which arise resulting directly or indirectly from the employee's contact with such chemicals with which the average physician is unfamiliar. The causes of such manifestations of industrial disease are very often found only by extensive research in special laboratories.

RECOMMENDATIONS

With its meager information the committee does not feel that it has acquired sufficient data on which to base recommendations. It may, however, make a few suggestions as a basis for the continuation of its work.

1. The committee should be continued, but under the name of "Committee on Industrial Health and Hygiene".

2. The membership of the committee should include two or more physicians who are directly and intimately connected with the large industries as chiefs of their medical departments.

3. An extensive survey should be made of the *Health and Hygiene of Industry*, as a feature of The Medical Society of New Jersey, in collaboration with various organizations interested in this same activity.

4. Under the Post-Graduate Instruction Committee there should be established an opportunity for instruction to the physician in industrial health and hygiene, and in the recognition and treatment of the unusual industrial diseases.

5. The question of *preemployment examination* should be considered and studied, and some method found to place the physically

under-par individual in an occupation fitted to his physical defect.

It is evident, from the recent activity in the subject of industrial health and hygiene, that effort is being made to obtain authentic and accurate statistics of the conditions in industry; to obtain sufficient data on which to base recommendations whereby the health and well-being of the large number of employees may

be improved; and to find a *modus operandi* to produce the hoped-for results. We feel that The Medical Society of New Jersey will be the prime mover in accomplishment in this field.

Respectfully submitted,

J. IRVING FORT, *Chairman*
LESLIE EDWIN MYATT, *Vice-Chairman*
CHARLES LITWIN
TRAUGOTT JOHN SCHUCK
JAMES HERBERT SPENCER, JR.
WILLIAM FRANCIS COSTELLO, *Consultant*

The Advisory Committee on Medical Care of the Indigent and Low-Wage Group had for its objective the study of the indigents of New Jersey, with an attempt to permit them free choice of physicians. The Committee also had

as its objective to secure the coöperation of the physicians of New Jersey in caring for the low-wage group at reduced fees.

The very complete report of Dr. George W. Fithian, which follows, is conclusive proof of how well that committee has functioned.

REPORT OF THE COMMITTEE ON MEDICAL CARE OF THE INDIGENT AND LOW-WAGE GROUP

By GEORGE WASHINGTON FITHIAN, M.D., Chairman, Perth Amboy, N. J.

To the Sub-Committee on Medical Practice:

The Committee on the *Medical Care of the Indigent and Low-Wage Group*, which is an



advisory committee to the Committee on Medical Practice, begs to report that after due deliberation and many conferences it can find no better plans than those which were in complete agreement with the old E. R. A. administration. The committee therefore begs to

call your attention to the agreement that was drawn between the administration and the State Medical Society, as reported in the *Journal*, August, 1933, on page 593; and as described in the report of the Advisory Committee on Medical Care of the Indigent for the year 1937. (*Jour.*, April, p. 275.)

Any further action is contingent on the action of the State Legislature in providing the necessary funds. It has been the privilege of some of the members of this year's Committee on Medical Care of the Indigent and Low-

Wage Group to be members also of the New Jersey Health and Welfare Conference Committee that was appointed by the Governor, and through this membership to obtain some very definite facts as to the degree of medical indigency in the State of New Jersey. We have found that the number of medically indigent is far greater than had been generally realized.

The term *medically indigent* covers both those people who are on relief and those whose income after paying for food, shelter and clothing is not sufficient to pay also for medical services. There are therefore two groups: one, which is on direct relief in some form; and another, which is in need of medical assistance only.

The Committee on the Care of the Indigent, which is a sub-committee of the New Jersey Health and Welfare Conference Committee, with the help of the State Finance Assistance Commission and the Department of Institutions and Agencies, has been able to initiate a statistical study for New Jersey, which corresponds to the categories mentioned in the National Health Survey, April, 1938, was taken for this statistical survey in order to correspond to the National Survey. For that month the direct relief load is approximately as follows:

- 400,000 persons in families on work relief (W. P. A.).
- 286,000 persons receiving general direct relief.
- 30,000 persons in families of persons in C. C. C.
- 31,000 persons in households receiving old-age assistance.
- 50,000 persons in families receiving mothers' aid, or aid to dependent children.
- 2,000 persons miscellaneous.

This group comprises a total of over 800,000 persons who were dependent upon the Government for food, shelter, and medical care. We revised and checked these figures; and in order to be reasonably conservative we have reduced the number to 750,000, or one-sixth of the total population of the State. We also surveyed the relief load for September, 1937, and here we found a total of over 600,000, or 25 per cent, less on direct relief. This date was taken because it represents the lowest relief load which has been reached since 1929. We quote from a preliminary report of the New Jersey Health and Welfare Conference Committee:

To determine the medically needy population among those not on relief, but lacking funds to pay for medical care, it was necessary to make up estimates by a number of yard-stick factors. Taking the estimated minimum subsistence budget which has been worked out carefully to discover eligibility for relief and C. C. C. enrollment, we learned that at present in New Jersey a family of four requires \$64 per month, or \$768 per year, to live on. This budget does not include any allowance for medical care or recreation. We concluded, therefore, that any family of four, receiving less than \$800 per year, or its equivalent in New Jersey, is unable to pay anything for medical service. By various

means we tried to estimate the total number in this group.

In hospital clinics we found about 50 per cent of those applying belong in this category; and 50 per cent on direct relief. From the hospital survey of 1937 we learned that 68 per cent of all hospital in-patient days were for ward care. A number of national and State surveys, added to the other data we have accumulated, help us to estimate conservatively that an equal number of persons in the total population must be classed in this division of the medically needy group. Thus there is a total of one-third of the total population which is unable to pay for any medical service, and where catastrophic illnesses, such as serious operations, are involved, the percentage is much higher. Over two-thirds of hospital patients' days in the general hospitals of the State are rendered to people who are unable to pay the doctors anything, and who reimburse the hospital less than half.

The Committee on Medical Care of the Indigent and Low-Wage Group of The Medical Society of New Jersey endorses the report of the Committee on Voluntary Health Insurance in its recommendations for voluntary insurance for the low-wage group, and its list of fundamental principles. (Journal, March, 1939, p. 165.)

Your committee believes that the ideal plan would be one which makes use of the best of the Ontario Plan, the State Society Agreement with the E. R. A., and the present plan of the Municipality of Perth Amboy, N. J., which is a modification of the old so-called "Middlesex Plan" and which the State Finance Assistance Commission seems to like.

Respectfully submitted,

GEORGE WASHINGTON FITHIAN, *Chairman*
DAVID WRIGHT GREEN, *Vice-Chairman*
FRANK L. FIELD
DANIEL LEO HAGGERTY
WARREN DAVID ROBBINS
BYRON GRANT SHERMAN
EDWARD MATHIAS ZEH HAWKES, *Consultant*

The Advisory Committee on Nursing and Nursing Education, under the very competent leadership of Dr. A. Charles Zehnder, cooperated with other agencies to provide nursing care for the ill and injured of New Jersey at

all economic levels. The plans that this committee instituted and the results obtained by them are clearly set forth in Dr. Zehnder's report, which follows:

REPORT OF THE ADVISORY COMMITTEE ON NURSING AND NURSING EDUCATION

By ANTHONY CHARLES ZEHNDER, M.D., Chairman, Newark, N. J.

To the Sub-Committee on Medical Practice:

The objectives of the *Committee on Nursing and Nursing Education* are to improve and perfect the plans which we had arranged in the previous years.



TRAINING NURSING ATTENDANTS

The first topic considered was to provide available places where nursing attendants could receive their technical training. This we accomplished by finding that it could best be given in convalescent hospitals and homes, day nurseries, homes for the aged, and community welfare homes for the indigent. We now have the training of the nursing attendant well established, in the three girls' vocational schools of New Jersey. This course should receive more publicity so as to attract more women to take it.

MEDICAL SECRETARIES

We also succeeded in establishing a course for the training of medical secretaries, for private physicians in their offices. This course is given at the Essex County Girls' Vocational School and is a popular one, more so than the one given for nursing attendants.

DEGREE IN NURSING

Seton Hall College is providing a course leading to the degree of Bachelor of Science in Nursing Education. This course is open to

graduate nurses. It qualifies them to assume teaching positions in nurses' training schools.

We have in previous years adopted the principle that the didactic training for the graduate nurse should be given before the student nurse receives her practical bed-side training. To apply this principle, we considered whether it was possible to provide the didactic training in schools not connected with hospitals, in order to relieve the hospital of the cost of this training. We have consulted with members in the field of education, and have been advised that it would not be advisable to change the place of this branch of training at the present time. Then too, we must consider the fact that the present system has been so universally established that a change could not be suddenly made without the expenditure of large sums of money; and this would not be popular in these times of economic depression.

This topic will have to receive more study and publicity among hospital authorities, the general public, and nursing groups before it can be put into effect.

We could, in the future, study the possibility of arranging for this instruction to be given in the State Normal Schools, where at present there are not a sufficient number of students to run the schools to capacity. With this in mind, our committee will continue to study the problem.

Respectfully submitted,

ANTHONY CHARLES ZEHNDER, *Chairman*
GEORGE MILTON KNOWLES, *Vice-Chairman*
HORACE WESLEY JACK
VICTOR KNAPP
FRANK LESLIE PERRY
HARRY SUBIN
THOMAS J. FRANCIS WALSH
WELLS PHILLIPS EAGLETON, *Consultant*

The Advisory Committee on Pharmaceutical Problems had as its objective the advancement of pharmaceutical practices throughout New Jersey in which they coöperated with the pharmacists of this State.

You have all received the third edition of the New Jersey Formulary which, indeed, is a creditable concrete evidence of the efficiency

with which this committee under the untiring leadership of Dr. Chester I. Ulmer, did function. Although there had been two previous editions, this third one was the first that was distributed to every member of the Society.

This sub-committee would respectfully request that next year the advisory committee be given the additional duty of considering the Pure Food and Drug Act.

REPORT OF THE ADVISORY COMMITTEE ON PHARMACEUTICAL PROBLEMS

By CHESTER ISAAC ULMER, M.D., Chairman, Gibbstown, N. J.

To the Sub-Committee on Medical Practice:

Our committee's chief effort during the past year has been the publication and distribution of the New Jersey Formulary, third edition. A copy was mailed to every member of the State Society and also to each member of the State Pharmaceutical Association. This is the most practical and effective way to bring the formulas to the attention of the individual physician. Heretofore the distribution of the Formulary was unsatisfactory, for only a small number of physicians received a copy.

NEW JERSEY FORMULARY

The New Jersey Formulary can be used effectively to perfect prescription writing, and particularly to combat the tendency to prescribe certain proprietary preparations. Reports from our members all over the state indicate that many physicians are making good use of the book. It is hoped that many more physicians will familiarize themselves with this group of ethical formulas, and prescribe them frequently. By so doing, the art of prescription writing will be revived and the cost of medication to patients materially lowered.

RADIO ADVERTISING

The practice of medicine by radio is a constantly growing menace to both the laity and the profession. Too long has the public been

compelled to listen to a lot of medical bunk relayed over the air by uninformed lay persons who use a health talk merely to camouflage the promotion of certain proprietary medicines. Since much untrue and distorted medical advice is put out over the air by certain commercial firms, it seems necessary that strong efforts be made to correct these abuses. Therefore, our committee is coöperating with the Committee on Professional Relations of the New Jersey Pharmaceutical Association in an endeavor to curtail the extravagant claims and statements that are frequently being made over the air. The radio resolution adopted by our House of Delegates last year, and which was forwarded to all of the leading broadcasting companies, has opened the way for our joint committee's efforts.

OBJECTIVES

There is a very noticeable and increasing degree of coöperation between the medical and the pharmaceutical professions in our State. The closely woven interests of the two professions require a mutual understanding. Our committee feels that the best way to promote a coöperative and friendly attitude between the two professions is to have joint meetings of physicians and pharmacists. Several of these meetings have already been held, chiefly in North Jersey. It is our recommendation that each County Society, in its program arrangement for next year, plan to have a joint meeting devoted to a discussion of joint problems.

Respectfully submitted,

CHESTER ISAAC ULMER, *Chairman*
REEVE LESLIE BALLINGER, *Vice-Chairman*
JACOB JOHN MANN
MERWIN LESTER HUMMEL
CHARLES JOSEPH MURN
DANIEL WOOLSEY TELLER, JR.
RALPH KING HOLLINSHED, *Consultant*

The Advisory Committee on Workmen's Compensation has studied our compensation laws and those in other states. Dr. Harry N.

Comando, the Chairman of that committee, desires to report as follows:

REPORT OF THE COMMITTEE ON WORKMEN'S COMPENSATION

By HARRY NOAH COMANDO, M.D., Chairman, Newark, N. J.

To the House of Delegates:

The objectives of this committee as enunciated by the Chairman of the Medical Practice Committee are as follows (Jour., June, 1938, p. 378):

A. Study compensation laws in other states, and the reports of previous committees of this Society.

B. Coöperate with labor, industry, and the Department of Labor in formulating an im-

proved Workmen's Compensation Act for New Jersey which will safeguard the interests of employees, employers, and private practitioners.



Your committee has kept the objectives in mind, and has faithfully studied the New York Compensation Act; and has gathered information from the executives who are working in the operation of the New York State Compensation Act, and from executives of insurance companies operating both in New York and in New Jersey. It has also studied the reports of previous Workmen's Compensation Committees, also the reports of the Joint Commission on Study of Workmen's Compensation Act and Practices (of 1933 and 1934).

As a result of all this study, your committee has come to the conclusion that, on the whole, the Workmen's Compensation Act of New Jersey is a fairly good law. (Jour., Jan., 1939, p. 38.) A great many abuses have developed in its operation. The amendments to the law from the time it was first written have not been adequate in rooting out these abuses. We feel that either a new Compensation Law should be written, or the present act amended. The new law when written should among other things embody the following principles:

1. The injured or diseased worker should have the right to select his own physician, providing proper safeguards were included protecting him against unqualified or incompetent services and preserve unto his employer the right of consultation, etc.

2. Your committee was of the further opinion that all doctors employed in compensation work by the State should be full-time employees of the Department and not be permitted to engage in any other work.

3. Your committee were in agreement, or

if not in full agreement, in near accord, that all clinics conducted by insurance carriers and manufacturers should cease caring for injured or diseased workers, except as first aid or emergency treatment.

4. Your committee felt that the Act should be changed as it relates to hernia, in that the payment for services to physicians in the cases of hernia should be separated from the hospital bill, and that an allowance of \$100 should be made a physician for operating a case of hernia.

As you have probably noticed, most of these recommendations are nothing more than a repetition of similar recommendations by Dr. Kraker's and Dr. Fort's committees.

We would particularly recommend for your consideration the report of a previous committee composed of Drs. Kraker, Aranson, Blumberg, Van Ness, and Dr. LeRoy Wood.

The Commissioner of Labor, Mr. Toohey, I believe, will be very coöperative, as his one desire is to have a well-functioning act. Labor is dissatisfied with the act that is at present operating, and would welcome a change.

Our policy, which for the past five years has been one of waiting and seeking information, should now be changed to one of action. We recommend that the Legislative Committee, or some other committee, get in conference with Commissioner Toohey in order to find out if the Department would present a bill supported by organized medicine.

Your committee is greatly indebted to Mr. Stephen J. Lorenz for his technical advice, and also to Dr. Andrew F. McBride for his counsel and advice.

I also wish to thank the members of the committee for their faithful efforts.

Respectfully submitted,

HARRY NOAH COMANDO, *Chairman*
JOSEPH FRANCIS LONDRIGAN, *Vice-Chairman*
WILLIAM KLIPSTEIN HARRYMAN
V. EARL JOHNSON
HENRY HOWARD KESSLER
CEDRIC C. CARPENTER
FREDERICK WILLIAM SHAVER
DANIEL F. FEATHERSTON
ANDREW FRANCIS MCBRIDE, *Consultant*

CONCLUSION BY DR. ALLMAN

I believe that it will be plainly evident from the reports above submitted that all of the Advisory Committees of the Medical Practice Committee have functioned earnestly and well. The splendid spirit of coöperation which has prevailed throughout the entire Medical Society this year was reflected and manifested by these committees, and I cannot too strongly praise each and every Advisory Chairman, nor can

I thank them sufficiently for their untiring efforts and their unselfish sacrifices.

Respectfully submitted,

DAVID BACHARACH ALLMAN, *Chairman*
SPENCER TREADWELL SNEDECOR, *Vice-Chairman*
HARRY NOAH COMANDO
GEORGE WASHINGTON FITHIAN
JACOB IRVING FORT
WILLIAM WALLACE MAVER
REUBEN LORE SHARP
CHESTER ISAAC ULMER
ANTHONY CHARLES ZEHNDER
THOMAS KRAFFEL LEWIS, *Consultant*

THE SUB-COMMITTEE ON PUBLIC HEALTH AND ITS TEN ADVISORY COMMITTEES

REPORT OF THE SUB-COMMITTEE ON PUBLIC HEALTH

By STANLEY NICHOLS, M.D., Chairman, Asbury Park, N. J.

To the Welfare Committee:

It is with deep sorrow that this committee opens its report by expressing its grief at the great loss, both to the committee and to the State Society, of two faithful members of many years' service, Dr. Theodor Teimer, of Newark, and Dr. I. W. Knight, of Pitman, who passed to their eternal reward during the past year.



A YEAR OF PROGRESS

The eighth year of service of this committee and its advisory committees has been the most fruitful year of progress toward the objective of this committee since its organization, namely:

The assumption of leadership and responsibility for the general health of the citizens of New Jersey by the State and County Medical Societies and their member physicians.

For the details of these accomplishments the Society membership is referred to the reports of the meetings and activities of our committees in the State Journal, and the records of the ten sub-committees, each of whose chairmen will render an annual report. Before mentioning some outstanding highlights of the year, we would like to briefly review this assumption of leadership on the part of the State Society, and the county societies and their physician members.

PUBLIC HEALTH AND OUR STATE SOCIETY

Every member of the State Society who wonders what the State Society is doing to protect his interests, should occasionally attend the bi-monthly meetings of the *Welfare Committee* and its constituent committees, and see for himself what a tremendous amount of self-sacrificing activity the numerous committees of fellow members, meeting in that beehive, put forth on his behalf. A visit to this scene of activity will do two things for a member of the Society. First, it will give him courage to find that so many of his fellow members are sacrificing much time and effort on behalf of

the preservation of the dignified practice of medicine in the face of numerous challenges and threats which has assaulted it from many sides during recent years. Second, it will give him pride in the fact that his State Society is busily engaged in meeting individual health problems, county health problems, and State health problems of all kinds.

PUBLIC HEALTH AND OUR COUNTY SOCIETIES

From the standpoint of public health responsibilities, the county societies have made increased strides during the past year. Many county societies have done excellent work in surveying their county public health needs and in coöperating with other groups. Progress in meeting those needs have been most gratifying.

Some of the county societies still have considerable room for improvement in this regard, but all have taken definite steps to duplicate, as far as possible within each county society, the State Welfare Committee and sub-committees, and have met the many challenges to the medical profession in our counties, with commendable resourcefulness and activities.

THE INDIVIDUAL MEMBER IN PUBLIC HEALTH

While the State and county societies during the past years have made rapid strides, there is still a great deal to be done toward our permanent objective of:

Helping preserve the best in private practice, by making every physician's office in New Jersey a health center for the practice of preventive medicine.

Our member physicians, busy with the all-absorbing problems of keeping up to date in medical science, curing the sick, and doing what they can to prevent disease, have not yet had sufficient aid and assistance from their county and State Society along the lines of preventive medicine in private practice, and of helping them develop the field of continuous health supervision of all of their patients from the cradle to the grave. These activities embody the real practice of preventive medicine of the future.

Perhaps also, some of our member physicians have not as yet fully realized how tremendously important to the preservation of their own practice is this development of health

supervision and preventive medicine. Every physician should note that the sincere objective of every public health movement in this country today is to develop better preventive medicine and better health supervision.

The time has now come, with every possible aid from State and county societies, for each physician to develop, to the best of his ability and for the good of his medical clientele, this largely undeveloped field of health supervision and all phases of preventive medicine. Our collective lack of such development in the past has left the physician's field wide open to the present irruption of numerous non-medical groups in these open gaps we have left in this field.

The time is now ripe for each physician, with the help of State and county medical societies, to make a determined effort to fill these gaps in his own private practice, and thus to stay the compulsory regimentation of the medical profession.

The only way we can produce better quality of public health, and better quality of medical care, is by each physician assuming the health supervision and the preventive medical care of his own clientele.

ADVISORY PUBLIC HEALTH COMMITTEES AND THEIR CONTACTS

The ten advisory committees, in their special health fields, have made outstanding progress during the year, working with the State Departments and all other health organizations of this State.

The largest part of this development has naturally been in connection with the State Department of Health and its various bureaus covering definite health fields. The finest type of close inter-relationship, coöperation and mutual coördination of personnel and plans has been developed with the State Department of Health in the fields of Child Health, Maternal Health, Cancer Control, Pneumonia Control, Venereal Disease Control, and Tuberculosis Control, etc. Our Crippled Children's Committee works similarly with the Crippled Children's Commission; our Mental Hygiene Committee with the State Department of Institutions and Agencies (whose interest in this field is paramount); our Traffic Accidents Committee with the Commissioner of Motor Vehicles; and our Occupational Disease Committee with the Department of Labor; and our Child Health Committee with the State Department of Education as well as with the State Department of Health.

In addition, these committees have worked in the closest coöperation with the Health Officers' Association of the State, the New Jersey

Sanitary and Health Association, the other health professions and the various health agencies, such as the New Jersey Tuberculosis League, and many other professional and lay groups interested in health.

These committees now function with able and experienced membership and chairmen and well deserve the thanks and appreciation of every member of The Medical Society of New Jersey.

THE PUBLIC HEALTH OF THE NATION

The three most important developments during our lifetime, which can affect for better or for worse the whole Public Health and medical care of the American people, took place during the year just passed. They were The National Health Survey, The National Health Conference, and the introduction of the Wagner Health Bill into Congress, which was designed to translate the recommendations of that Conference into law.

The health and medical care plans proposed by these developments were so extensive and the contemplated eventual costs thereof so enormous as to fairly stagger the imagination. But, it seems likely that circumstances have arisen which may slow down the too-rapid and unhealthy expansion of these developments, and perhaps give opportunity for careful study and controlled experiments in certain places, to ascertain the desirability of many of the plans and proposals embodied therein. The present tendency, which is more compatible with traditional professional thought and experience in the Public Health and Medical Care fields is toward a return to the time-honored and slower method of improving these services by gradual education and evolution, and demonstration on small scales. We sincerely trust that this slowing-down process may continue, in order that wise consideration may be given by all concerned to the proper balance between the powers of the Federal Government, the states, the communities, and the individual, to the end that sound and orderly progress shall continue, and the traditional American way may be preserved.

THE PUBLIC HEALTH OF NEW JERSEY

In November, 1938, Governor A. Harry Moore of New Jersey wisely appointed a representative advisory committee, under the chairmanship of Dr. Robert C. Clothier, President of Rutgers University, to study the National Health Survey and Conference recommendations and compare them to New Jersey's needs.

Governor Moore's committee on the Na-

tional Health Survey has been busily engaged in carrying out the health studies and will make its recommendations in the late Spring or early Summer of this year. Proof as to the value of these studies can be found in the set-up, based on the inescapable conclusion that a sound Public Health Program must be built like a three-legged stool, all three legs of which are essential to its proper development and continued support, as follows:

Number 1. Function—*Service*, by professional service groups, six in number (medical, dental, nursing, pharmaceutical, hospital, and medical-social service professions).

Number 2. Function—*Administration*. Public Health officials and other public officials having to do with some phase of health.

Number 3. Function—*Promotion, Publicity, Raising of Funds*, etc., by lay health agencies and other lay agencies having some phase of health in their programs.

RECOGNITIONS

Our committee wishes to offer its thanks to the President of the State Medical Society, the Vice-President and officers, and the Chairman of the Welfare Committee, and Dr. LeRoy A. Wilkes, the Executive Secretary, and his office staff, and Dr. Frank Overton, Editor of the Journal, for their aid in the improvement of the functioning of the various units of the State Society which made possible better work on the part of all committees.

We particularly wish, at the expiration of his presidential year, to congratulate President Carrington on his devotion to the needs of the Society during a very crucial year, and the skill and ability which he demonstrated by his fine leadership of the affairs of the State Society.

We wish to offer the thanks of The Medical Society of New Jersey and our committee to all of the physicians and laymen who have aided us in the heavy tasks we have carried on during the past year; and particularly to the members of the committee itself, and to the chairmen and members of the advisory committees: the Committee on Cancer Control, Dr. William G. Herrman, Chairman; the Committee on Maternal Welfare, Dr. Arthur W. Bingham, Chairman; the Committee on Venereal Disease Control, Dr. C. Byron Blaisdell, Chairman; the Committee on Mental Hygiene, Dr. James S. Plant, Chairman; the Committee on Tuberculosis Control, Dr. A. E. Jaffin, Chairman; the Committee on Child Health, Dr. Walter Stewart, Vice-Chairman; the Committee on Crippled Children, Dr. Barclay W. Mofatt, Chairman; the Committee on Adult

Health Supervision, Dr. Herschel S. Murphy, Chairman; the Committee on Pneumonia Control, Dr. Robert Kilduffe, Chairman; the Committee on Traffic Accidents, Dr. Elbert Sherman, Chairman; the Commissioner of the State Department of Labor, Commissioner J. J. Toolhey, and his representative, Dr. Kessler; the Commissioner of the State Motor Vehicle Department, Hon. Arthur Magee, and his representative, Arnold Vey.

We also appreciate the coöperation of the State Board of Health and its personnel, particularly Dr. Irving Deibert, President of the Board; Director J. Lynn Mahaffey, Assistant Director Mr. Edmund R. Outcalt, Mr. William H. MacDonald, Chief of the Bureau of Local Health Administration; Dr. Julius P. Levy, Chief of the Bureau of Maternal and Child Health; Dr. Karl M. Scott, Acting Chief of the Bureau of Venereal Disease Control; and many other bureau officials of the State Department of Health; the officers and committees of the New Jersey Parent-Teacher Association, the Health Officers' Association; and the committees of that Association working with the health committees of the State Society; the New Jersey Health and Sanitary Association; the Public Health Chairmen and members of the County Public Health Committees of the county medical societies; the advisory members from the State Department of Education, and the State Department of Institutions and Agencies; the State Tuberculosis League; the State Crippled Children's Commission (Mr. J. Buch, President); and the many official and non-official health agencies who have materially assisted our county and State societies in solving these health problems; and the many other physician members and lay persons who have participated in a most helpful way in the efforts of our committee to carry the heavy load placed on us continuously during the past year.

RECOMMENDATIONS

Recommendation Number 1. That The Medical Society of New Jersey and its component county medical societies continue their leadership and responsibility for the general health of the citizens of New Jersey, and coöperate with health and other public officials and lay agencies toward that end.

Recommendation Number 2. That the county societies annually *survey their counties* as to their Public Health needs, and show the ways by which they can lead in providing for these needs, in conjunction with the local health departments and official and non-official health and welfare agencies—this leadership by the

county societies to be an important, continuing function in every county society.

Recommendation Number 3. That the members of this Society be urged and assisted by all possible means, to develop in their own clientele, as much preventive medical service as they possibly can, together with the promoting of continuous health supervision of all of their patients for the purpose of thus improving the quality of medical care.

Recommendation Number 4. That The Medical Society of New Jersey send resolutions of thanks and appreciation to the State Department of Health of New Jersey, and all of the many other State public and private health and welfare agencies who have coöperated with our Society in our many Public Health projects during the past year.

Recommendation Number 5. That the incoming officers be requested to give consideration to integrating, by whatever means seem wisest, provisions in our Public Health program for eye problems and prevention of blindness; prevention of deafness; and the control of cardio-vascular-renal diseases and diabetes.

Finally, we would like to express our pride in the Public Health progress of The Medical Society of New Jersey. This has been made possible by the fact that the medical profession in New Jersey, as elsewhere in the United

States, has been able, in spite of unwarranted attacks from many quarters, to continue to see the problems of Public Health and Medical Care in a realistic way, and following the traditions of our profession, have accepted, as a Society, the responsibility for the health of the public, in addition to the past responsibilities of the individual physician for the health of his private patients. This has resulted in a *careful* study of these problems, *conference* with other groups interested in health, and joint *attack*, looking toward the solution of the problem in an orderly way, to the end that a *better* quality of Public Health and a *better* quality of Medical Care shall be rendered to New Jersey's citizens by the members of The Medical Society of New Jersey.

Respectfully submitted,

STANLEY NICHOLS, *Chairman*
FREDERIC WILLIAM LATHROP, *Vice-Chairman*
FRANK A. BIEN
ARTHUR WALTER BINGHAM
CHARLES BYRON BLAISDELL
JACOB IRVING FORT
ERNEST GARFIELD HUMMEL
ALLEN GILBERT IRELAND
ABRAHAM EZRA JAFFIN
ROBERT ANTHONY KILDUFFE
ISAAC WARNER KNIGHT (deceased)
JULIUS LEVY
BARCLAY WELLINGTON MOFFAT
HERSCHEL STRATTON MURPHY
HENRY BOYLAN ORTON
JAMES STUART PLANT
ELBERT STETSON SHERMAN
THEODOR TEIMER (deceased)
EDWARD MATHIAS ZEH HAWKES, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON ADULT HEALTH SUPERVISION

By HERSCHEL STRATTON MURPHY, M.D., Chairman, Roselle, N. J.

To the Sub-Committee on Public Health:

Realizing that Adult Health Supervision is a very broad field, our Committee, this year, has set down a certain number of objectives which we hope can gradually be fulfilled over a period of years. While there is some overlapping of the activities and scope of various committees of the State Medical Society, we feel that the following subjects merit our attention:



(1) The Annual Birthday Health Examination.

(2) A survey of the needs and facilities for care of the following diseases, especially the more chronic cases:

- a. Cardiac diseases.
- b. Rheumatism.
- c. Arthritis.
- d. Arterio-sclerosis.
- e. Digestive diseases.
- f. Diseases of the eye and ear.
- g. Apoplexy.
- h. Diabetes.

THE HEALTH EXAMINATION

Feeling that probably one of the best approaches to this subject is through the annual birthday health examination, we concentrated most of our efforts on working out a plan whereby we could convince both the public and the family physician that his office can and should be a health center in the education and care of people with chronic diseases. While the public is not yet fully persuaded that the physical examination is a life-saving and health-giving measure of the first importance, it is doubtful whether any public health measure is more fundamental in preventing illness and increasing the length of life. The success with which the examining physician's advice is carried out will determine the efficiency of the periodic examination as a means of raising the level of health through middle age.

Our Committee approved of the Periodic Health Examination blank that was devised by the Adult Health Committee last year. It is intended that this blank be filled out by the

physician at the time of the annual examination and that he give it to his patient to take home with him to show his family. The physician may keep his own findings on any type of card he pleases for his permanent records.

We recommended that a small pamphlet of several hundred words, carrying a convincing argument in favor of the annual birthday health examination, be drafted by the Public Relations Committee, with the approval of our Committee. It was felt that a copy of this pamphlet, along with one of the Periodic Health Examination blanks, should be mailed free by the Executive Office in Trenton to each member of the State Medical Society, with an explanatory letter telling him that additional copies of each can be purchased at cost from the Executive Office. This leaflet is intended to be placed in the physician's waiting-room for patients to read, and take home with them. It is our hope that the Field Physicians will talk up this program as they visit the various doctors in their respective counties.

BIRTHDAY GREETINGS

We hope that during the remainder of this year and those to come, physicians throughout the State will begin to make a note of the birthday of each patient as he comes to the office. A card, wishing the patient a "Happy Birthday," and calling his attention to the fact that he is a year older and that it is time for his yearly health examination, should be sent by the doctor on each birthday.

RADIO

If it were possible to have the American Medical Association approve, and a combination of ethical drug houses finance, an evening radio program, either dance music or a well-known comedy skit, to popularize the Annual Birthday Health Examination, this would be of great value.

If we can see the idea of birthday health examinations gradually meeting with universal approval throughout the State, we will feel that we have not worked in vain.

Respectfully submitted,

HERSCHEL STRATTON MURPHY, *Chairman*
WILLIAM HENRY VARNEY, *Vice-Chairman*
EDWIN GRAFING DEWIS
ROBERT MARTIN GRIER
EDWARD CAFFRON KLEIN
AUGUSTUS S. KNIGHT
ADOLPH TOWBIN
WATSON BUDLONG MORRIS, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CANCER CONTROL

By WILLIAM GETTIER HERRMAN, M.D., Chairman, Asbury Park, N. J.

To the Sub-Committee on Public Health:

The Committee on Cancer Control has held the following meetings: June 5, October 2, December 4, and February 19, which were regular stated meetings set down by President Carrington. The committee met on each of these dates prior to the meeting of the Welfare Committee, according to the calendar, and will again meet on April 16 for consideration of a supplementary report. In addition to these stated meetings the committee met also in the evening of November 8 at the Stacy-Trent Hotel; and an additional and joint meeting was held on Sunday, December 18, with the Chairman or other representative of the Cancer Committee of the various county societies. A report on the work of these meetings has already been published in the Journal. In addition to these special meetings the Sub-Committee on Cancer Control met with the special committee of Board of Trustees on Sunday, February 5.

The report of the committee of last year reaffirmed the Coöperative State Program of Cancer Control submitted by the committee in April, 1935, and left with this year's committee two main problems.

FACILITIES FOR HOPELESS CANCER CASES

Last year's committee held several conferences with the Commissioner of Institutions and Agencies, and with the State Association of Freeholders, in regard to increasing the facilities for the care of the homeless and hopeless sufferer. The committee was received with courteous attention by the Association of Freeholders but the net results of that meeting was that the various Boards of Freeholders recommended that the State establish a hospital for the care of the cancer sufferer. Last year's committee did not approve of the hopeless sufferer being taken out of his county, but desired that each Board of Freeholders would provide means either (a) in a general hospital for those still needing medical care even though they were incurable, or (b) through amplified nursing service for those who could still be cared for at home but did not have the means to

pay the necessary nursing, or (c) for care in county welfare homes applicable to those who did not need any special medical care but only nursing care in relief of pain and who had no home.

The committee this year disapproved the action of the various Boards of Freeholders; and it is our understanding that many of the resolutions were recalled by the individual counties from which they were sent. Many counties have subsequently provided one or more of the types of care which we recommend. And we again ask that the State Society urge each County Board of Freeholders to consider these types of care for the incurable case, so that those in their last illness may remain near their loved ones and their friends.

THE CURIE INSTITUTE

The second problem left before the committee for this year was the further study of the organization known as the Curie Institute. At the meeting held on October 2, and the evening meeting November 8, Mrs. Peabody, the founder of the Curie Institute and a member of its executive committee, was present to lay before the committee the principles and purposes of the Curie Institute. At the special meeting held on November 8 the committee went on record as being in favor of the principles of the Curie Institute but the committee felt that there were still many points to be ironed out in regard to planning and organizing affiliations before the committee could give unqualified approval of the entire project. Many of the points under consideration we felt could not be settled until the Curie Institute actually started the treatment of cancer cases.

Briefly the purposes of the Curie Institute, which the committee approved in principle, were as follows:

1. The establishment of a special hospital, in some center of population, probably in Essex County, devoted to treatment, and to research and education of the profession in regard to cancer and allied diseases. Such an institution to possess the latest in radiation therapy apparatus. Both the patients treated and the staff of the institution to be drawn State-wide. The case to be treated in the central institution being one referred to it by an affiliated or other cancer group, and accepted because of its rarity, or difficulty in treatment, or its value in research.



2. The establishment of a central pool of radium, both elemental and gaseous, with provision for its distribution on a low-rental basis, or free to those qualified to use it throughout the State.

3. The establishment of affiliated groups associated with already recognized hospitals; and the affiliation of already established groups with the central institution. Such affiliation to depend upon character of personnel and ethical standards. Services of affiliated groups in central hospital to be given to both indigent and self-supporting. Fees to be consistent with the economic status.

4. The establishment of small nursing homes for the care of homeless and hopeless cancer cases whether they be indigent or not.

NATIONAL CANCER INSTITUTE

The National Cancer Institute has announced the availability of radium for distribution to institutions upon application to the National Institute, such applications to be approved by the State Department of Health. The present amount of radium, considering the size of the country, is comparatively small; but probably there will be additional radium purchased by the National Institute for distribution upon the payment of transportation and insurance charges. Information has been forwarded to each institution in the State and some applications have been made. Prior to the forwarding of such information to interested institutions, the manner of its distribution was thoroughly discussed by the committee and representatives of the State Board of Health, the committee volunteering to act as an advisory committee to the State Board of Health when requested.

COMMITTEE MEETINGS

At the first and second meetings of the committee the question of establishing a definite plan by our committee for the entire State was discussed, and since it was realized that the conditions, needs, and set-up in the several counties was so variable, it was decided to ascertain first just what were the difficulties and the set-up in each county; and that then the State committee should act so as to stimulate each county society to establish a definite program applicable to its own needs according to the local conditions. For this reason a special meeting was called in Trenton on Sunday, December 18. This meeting was quite well attended, there being twenty-seven men present from various counties and in addition President Carrington, the Executive Assistant, Dr. Norman Scott, and Mr. William H. MacDon-

ald, State Department of Health. Fifteen of the twenty-one counties were represented. The chairman requested at this meeting that before February first each county inform the chairman in regard to the following conditions:

1. Are there facilities for taking care of cancer cases as follows: Hospital beds, available competent surgeons, radiologists and pathologists?

2 (a). Do the county societies have a definite program? and if such program exists, does it provide for both (1) professional and (2) lay education? (b) Is there stimulation of tumor groups for the study of diagnosis and the treatment of cancer and allied diseases?

QUESTIONNAIRE

A questionnaire to this effect was sent out to each of the counties,—not only the fifteen represented but to the other six not represented. In answer to the questionnaire, reports were received from fourteen counties, eight of whom reported that they did have facilities. Of those who did not respond it was obvious that four did have such facilities, making a total of twelve counties with the proper facilities out of the twenty-one in the State. Three other counties reporting insufficient facilities stated that their cases were taken care of in adjacent counties. Of the reporting counties only seven stated that their societies had definite programs. One county reporting "No" stated that there was a program of professional education. Of those reporting a definite program all reported that professional education was part of such program. Five reported a program of lay education and eight reported that there were efforts being made to form tumor clinics.

PROGRAM FOR A SMALL COUNTY

As a result of this questionnaire a further study by the committee, it seemed advisable that the programs in the different counties might be outlined as follows for the small counties:

1. Stimulate interest of physicians in the study of cancer through programs delivered at the county medical meetings; and the formation of a committee for cancer control if one does not already exist.

2. Encourage the organization of groups to study cancer cases in the local hospital whether or not facilities exist for complete treatment.

3. Solicit the opportunity for representative of the county society to talk on cancer before lay groups, such as service groups.

4. Arrange affiliations with nearby already

established public or private facilities, so that patients may be informed where they may receive appropriate treatment for their case.

5. Urge local Boards of Freeholders to provide care, either in institution or at home, for the hopeless cases; and discuss with the Boards of Freeholders the subsidizing of the treatment of cancer in indigent cases.

PROGRAM FOR LARGER COUNTIES

In the larger counties, where facilities are entirely or nearly entirely adequate, the program might be as follows:

1. Continue to emphasize the importance of the recognition of cancer early to the general practitioner, especially pointing out (a) the value of precancerous lesions; (b) the importance of diagnosis as exemplified by tumor group study; (c) the importance of treatment planned in advance, and not decided upon as the growth advanced.

2. Support professionally, and as citizens, the already established facilities.

3. Continue the education of the public by (a) group meetings; (b) articles for laymen in the local newspaper.

4. Gather together statistics on mortality rates.

5. List the cures which are effected.

6. Give professional and moral support to lay groups where such organizations have been recognized by the State Society.

RECOMMENDATIONS

At the meeting on February 22nd, the report of the questionnaire was discussed, and in addition to the opportunities explained above, the committee passed upon the following questions:

1. In order to increase the effectiveness of the fight against it in New Jersey, should the committee establish a cancer commission the same as that established in other states such as Massachusetts, or New York, or New Hampshire, or Georgia? To this question the answer was "No".

2. The committee did feel, however, that a bureau in the State Department of Health concerned with coordination of the work of existing agencies, could be established somewhat after the plan of the bureau of the State of Connecticut.

3. The committee went on record as being in favor of the local care of the cancer case insofar as possible for both the hopeless sufferer and the one still amenable to medical care. The committee felt that only if this plan is tried and proved inexpedient should a State hospital be established; and that if such a hospital were established, its care should be very

largely confined to the homeless and hopeless cases, giving treatment to these as a last-minute effort to turn the tide. The committee favored very strongly the plan that, so far as possible, patients should receive treatment within twenty-five to thirty miles of their residence.

4. Committee felt that the plan of the Association of Clinical Pathologists for tissue examinations should be tried out before requesting the State Department of Health to establish a laboratory for tissue diagnosis.

5. The committee went on record as desirous of amplifying professional education in cancer; and requested that, the next time a Fall Clinical Congress of the Medical Society is held, there be a place on the program for a symposium on cancer treatment and diagnosis and that so far as possible there be an article each month in the State Journal on the subject of cancer.

The committee also recommends in addition that a definite effort be made in each county to develop diagnostic and therapeutic clinics. There are, at the present time, clinics approved by the American College of Surgeons in the following counties: Atlantic County, one; Bergen County, three; Essex County, five; Passaic County, two; and Union County, one. Eleven additional hospitals have cancer clinics not so approved as yet; and thirty-one hospitals have definite plans for establishing tumor clinics or study groups. There are still many communities and several counties who do not have facilities, and no effort has been made for affiliation with institutions in order to provide for the proper care of the residents of such communities or counties.

The committee feels that the State Society itself should establish standards for an approved clinic and that such approval might be taken over as one of the duties of the Cancer Committee in conjunction with the Board of Trustees and the Executive Office. These clinics should be established primarily for the care of the indigent and the low-wage group. Where patients are able to pay for services and the attendance only through the reference of a physician; and they should be expected to pay a fee both for diagnosis and treatment to the physician members of the clinic whose advice and services are sought. So far as possible where such clinics are established, all ward patients of the associated institution should have the study of the tumor group operating the clinic.

The committee further feels that the establishment of an institution to provide facilities for both clinical and physical research, and the treatment of obscure and difficult cases.

is highly desirable. Such an institution should also own plenty of radium for loan, and should have the services of physicists and consultants available to tumor groups within the State. Such an institution could soon take the lead in the education of physicians, both specialist and general practitioner. It could also develop an educational program for dentists and nurses and could accumulate a library of exhibit material and pathological slides, and establish a tumor registry.

The program outlined above, advocated by the committee, is the continuation of the program so ably outlined by the committee under the leadership of Dr. Orton in 1935. There are two lay groups seeking to develop chapters throughout the State:

1. The Curie Institute, for the purposes already described is encouraging and developing lay organizations in the various communities.

2. The American Society for the Control of Cancer is seeking to enlist lay members in the so-called *field army*. The purposes of this group are confined to the education of the laity. Your committee feels that the profession should give active support to both groups within their respective fields.

Respectfully submitted,

WILLIAM GETTIER HERRMAN, *Chairman*
HENRY BOYLAN ORTON, *Vice-Chairman*
HAROLD STERN DAVIDSON
ELLWOOD EMERSON DOWNS
JOHN BUTLER FAISON
OTTO RUDOLPH HOLTERS
JOSEPH HENRY KLER
AUGUSTUS S. KNIGHT
CHARLES B. WOODMAN
THOMAS BENJAMIN LEE, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CHILD HEALTH

By STANLEY NICHOLS, M.D., Chairman, Asbury Park, N. J.

To the Sub-Committee on Public Health:

The Child Health Committee has been busy during the year promoting many phases of the Child Health program, and particularly those mentioned in the objectives given at the beginning of the year, which were as follows:

1. Promote Child Health Supervision at all of the child age levels, by the Family Physicians, as follows:

- New-born and infants
- Pre-school age
- School age
- Adolescence.

2. Promote, by Public Health Hour and other means, the Control of Communicable Diseases in Childhood by Family Physicians—

- a. Individually.
- b. As coöperating members of their county medical societies.

3. Furnish capable speakers on child health topics, and other methods of educating the public on child health.

In addition the committee has served Dr. Ireland and the State Department of Public Instruction by acting in an advisory capacity on the many problems encountered in the school system of the State in regard to the children with heart disease.

At the request of the committee, one of its members, Dr. L. Charles Rosenberg, made a complete study of the present status of diph-

theria immunizations, which will be printed in the State Journal shortly.

The committee approved for adoption by the State Society the Standards for Medical Health Supervision and Care of Infants, which were created by the American Academy of Pediatrics.

RECOMMENDATIONS

The committee recommends:

1. That the objectives of the committee as stated, be continued.
2. That more effort be made by the members of the State Society to improve child health supervision at all four age levels, utilizing, where possible, the cards prepared by the State Society.
3. Improved post-graduate education by the State Society on the subject of Child Health.
4. That a brief summary of some important pediatric subject of timely interest to the general practitioner should be published in the State Journal every one or two months, to keep the membership stimulated to increased interest in health supervision of children.

Respectfully submitted,

STANLEY NICHOLS, *Chairman*
WALTER BLAIR STEWART, *Vice-Chairman*
ARTHUR FOWLER ACKERMAN
CHESTER BROWN
ERNEST GARFIELD HUMMEL
IRVING OKIN
LOUIS CHARLES ROSENBERG
ALDRICH CLEMENTS CROWE, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CRIPPLED CHILDREN

By BARCLAY WELLINGTON MOFFAT, M.D., Chairman, Red Bank, N. J.

To the Sub-Committee on Public Health:

Last July in stating the work for the year, the Crippled Children's Advisory Committee outlined its objectives in accordance with Dr. Nichols' report of the Public Health Committee as follows:



1. Coöperate with Crippled Children's Commission on all matters concerning the care of crippled children.

2. Integrate physicians with all public groups interested in

the care of crippled children.

3. Study the qualifications necessary of personnel, medical, nursing, physiotherapy, hospitals, etc., dealing with crippled children in this State.

4. Study all facilities available and other phases of development of the work for crippled children from the standpoint of The Medical Society of New Jersey.

As regards the first of these objectives, a number of problems put to this committee by the Commission were passed on with the result that the Commission's program is functioning smoothly from a medical point of view and has remained consistently decentralized. Almost without exception, patients are cared for in the county in which they reside.

The second objective has been carried out in seeking the coöperation of physicians caring for crippled children. The committee has been helped in this regard by the orthopaedic surgeons throughout the State with a generosity which this committee is glad to acknowledge. The necessary paper work involved in the follow-up of the treatment has been consistently carried out and the money paid by the Commission for hospitalization and braces through the medical channels set up by this committee has been most helpful.

The third objective has concerned this committee and will continue to do so; in particular, the two convalescent homes in the State have been, through the coöperation of their surgical directors, drawn more closely into the medical program of the Commission. It has been especially encouraging to note the willingness of orthopaedic surgeons throughout the State to meet the standards set up by this com-

mittee, and it is gratifying to this committee that the Commission has consistently refused to coöperate with hospitals which have not been approved by the College of Surgeons, with the sole exception of cases whose care by the Commission was initiated before the issuance of the College's list of approved hospitals.

The Commission has conducted a survey of the physiotherapy personnel, and on the advice of this committee is planning to pay for the physiotherapy after-treatment of cases which have been hospitalized under their program for a period of six months as an experiment, probably at the rate of fifty cents a treatment.

The Commission also conducted a survey of the visiting nursing facilities which brought out the fact that in some of the more rural counties the nursing staff is inadequate, indicating the need for four additional nursing supervisors on the staff of the Commission. The problems of furnishing orthopaedic training to visiting nurses was referred to this committee to act in conjunction with representatives of the Advisory Committee on Nursing to the Commission. This portion of the program is still to be worked out.

The question of available neurological consultations has been solved through the kind coöperation of Dr. Christopher Beling, of Newark, whose appointment to this committee was made at its request by Dr. Carrington. Whenever a neurological consultation is requested by any orthopaedic surgeon under the Commission's program, Dr. Beling is consulted and he designates the nearest competent neurologic clinic. The problem of qualified plastic surgeons is handled in a similar way through Dr. Greenfield's membership on this committee.

Under the last objective the committee has coöperated with the Commission in investigating the facilities for placement of crippled children in foster homes and their subsequent care. This work has just been started. The committee approved an invitation to physicians in the neighborhood of orthopaedic clinics, to be present, should the surgeon in charge express his willingness to watch the work of the clinic as a form of post-graduate instruction.

Respectfully submitted,

BARCLAY WELLINGTON MOFFAT, *Chairman*
ELMER PETER WEIGEL, *Vice-Chairman*
OSWALD RUDOLPH CARLANDER
FREDERICK GEORGE DILGER
WILLIAM GREENFIELD
EMANUEL HARRISON NICKMAN
TOUFICK NICOLA
HERBERT WILLIAM NAHEY, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON MATERNAL WELFARE

By ARTHUR WALTER BINGHAM, M.D., Chairman, East Orange, N. J.

To the Sub-Committee on Public Health:

The Committee on Maternal Welfare is carrying on a program similar to that outlined a year ago. Each county has had a Field Physician except during brief intervals in some counties due to resignations and delay in new appointments. The Field Physician carries on child health work as well as maternal welfare.



The Field Physicians have had regular meetings with the Director of Maternal and Child Health and the Chairman of the Committee on Maternal Welfare. The group from the southern counties meets in Trenton, and those from the northern counties meet in Newark.

The committee took an active part in the organization of the Section on Obstetrics and Gynecology at the Annual Meeting of the State Medical Society at Atlantic City.

The maternal mortality charts, ten in number, were exhibited at the Annual Meeting, showing the mortality rates for each county according to the five main causes of death. Application has been made for the exhibition of similar maps showing 1938 statistics at the American Congress on Obstetrics and Gynecology in September. Lantern slides of the 1937 statistics were shown at the obstetrical meeting of the American College of Surgeons in New York.

All maternal deaths have been investigated by the Field Physicians, and studied and classified by the chairman. The whole committee will meet soon to place the responsibility for these deaths.

The committee met on October 2, 1938, and discussed various subjects related to maternal welfare.

The Refresher Courses at Margaret Hague Maternity Hospital are being attended by more physicians than last year. We hope the number will continue to increase. Those who have attended the courses all agree they are well worth while. We are grateful to Dr. Cosgrove and his associates for this opportunity to observe modern obstetrical procedures.

The committee urges more obstetrical conferences in hospitals and in county medical so-

cieties. More are being held than ever before; but they should be held regularly in every county and in every hospital taking obstetrical cases. The chairman had the pleasure of attending a number of these conferences and found them very valuable. The discussion of how to avoid complications and how to treat them when they arise, as well as the study of maternal deaths, are of great assistance in the practice of obstetrics. Any member of the Committee on Maternal Welfare will gladly attend these conferences and discuss the cases, if invited.

A maternal welfare article has been published each month in the Journal of The Medical Society of New Jersey; and also a paragraph entitled "A Lesson from a Death Certificate" has appeared since September, 1938. These two features will be continued.

The Field Physicians obtained annual obstetrical reports from eighty-five hospitals and nursing homes for 1937. This covers practically all of the hospitals taking obstetrical cases, and a few nursing homes. So far eighty-eight reports have been received for 1938, which is an excellent showing; and the Field Physicians are to be commended for their good work. The hospital reports in one respect add to our troubles, for the deaths reported do not always agree with those reported by the State Department of Health. Sometimes more deaths are reported by the hospital than the State Department of Health has credited to that hospital, and sometimes the hospital is short one or two deaths. This is due partly because the death certificates and history sheets are not always made out by the same physician. Sometimes it is an intern who neglects to mention the fact that the patient was pregnant. Sometimes the contributing cause of death is given as the primary cause. It is then necessary to write the hospital and find out the names of the patients, and check them with the Department of Health list. Then we write the State Department of Health to find out the cause of death as given on the certificate. In some cases these are not finally classified as maternal deaths, and in other cases it is necessary to add another maternal death to our list.

It is to be hoped that this will lead to more accurate records being kept by the hospitals, and more care in filling out death certificates. From this study the committee feels that any State not receiving annual reports from its hospitals may not get a correct evaluation of its

maternal mortality rate. No doubt there are also errors in some of the records of deaths occurring outside of hospitals.

A summary chart for the use of all hospitals taking obstetrical cases is being prepared by the Executive Office of the State Society with the assistance of the Committee on Maternal Welfare. This form was exhibited by Dr. T. K. Graham, Field Physician for Passaic County, at the annual conference as used by the hospitals in that county. It was approved by the committee and others present. Dr. Carington suggested that it be printed by the State Society for hospital use.

The maternal mortality rate in New Jersey for 1938 is 3.5 per thousand live births; which is a little higher than for 1937. The failure to lower the rate is due to the fact that two or three counties had unusually "bad luck". Next year we hope for better "luck". Ten counties had a better rate than in 1937. Nine counties had a poorer rate than in 1937. Two counties maintained the same rate.

NEW JERSEY—1938

The death rate increased as follows:

From Puerperal Sepsis	18%
Hemorrhage	37%
Other Accidents of Childbirth	14%
Ectopic Gestation	50%

The death rate decreased as follows:

From Septic Abortion	31%
Non-septic Abortion	43%
Toxemias of Pregnancy	11%
Embolism	24%

There were 106 consultations under the consultation service paid for by the State Department of Health in 1938. All slips for these consultations were examined by your chairman and the following points were noted:

1. Whether or not the patient was in the low-wage group.
2. Reason for consultation.
3. Nature of advice given by consultant.
4. Whether consultant is a member of the State Medical Society.
5. School of medicine graduating the consultant.
6. Date of graduation of consultant.
7. Hospital appointments (if any) of consultant.

The slips are obtained from the Field Physician. Any competent consultant may be called, and he will be paid by the State Department of Health. A young physician in practice less than five years is not considered a competent consultant, unless he has had special training in obstetrics.

Nursing delivery service was used on 1,328 cases in 1938. Slips for payment of a nurse

called for delivery are obtained from the Field Physician; and when properly filled out by the doctor and the nurse they will be paid by the State Department of Health. These cases are checked by the Supervisor of Delivery Service.

A study of the maternal deaths for 1938 showed that, after deducting those due to ectopics and abortions, over one-third of those delivered at or near term had either no prenatal care, or poor prenatal care. The committee believes that every county has outlying districts where it is difficult to get the patients in the indigent or low-wage groups to attend a prenatal center on account of distance. In some counties this is more apparent than in others.

With this in mind, a new system of prenatal care has been proposed. The prenatal care is given by a physician in the neighborhood free of charge when the patient is referred to him by the Field Physician. The patient is first contacted by the Field Nurse, and her name is given to the Field Physician. The work is supervised by a committee consisting of the Field Physician as chairman, two physicians appointed by the President of the county society, and a representative of the Field Nurses.

This system is to be used only where there are no prenatal centers available. The two systems work together. If a prenatal center is within a reasonable distance, the Field Nurse will send the patient there; while if there is no prenatal center nearby, she will be referred to a physician's office by the Field Physician who has been notified by the Field Nurse of the patient's need.

The annual conference of the State Committee on Maternal Welfare with the county committees and Field Physicians was held in Newark on January 19th. It was opened at 3 p. m. with a showing of the film "The Birth of a Baby", sponsored by the American Committee on Maternal Welfare. After the showing it was approved by the State committee and others present for showing to the public.

Various phases of maternal welfare work were discussed, and Dr. Levy showed slides on neonatal mortality and explained their importance. There were over 200 physicians and nurses present. Fifty-five physicians attended the dinner which followed. In the evening a meeting at the Academy of Medicine of Northern New Jersey was attended when Dr. Harrison Martland, Medical Examiner for Essex County, gave a most instructive talk on "The Medical Examiner Looks at Obstetrics and Gynecology".

The committee feels that the physicians of the State are trying to give their patients better prenatal, delivery, and post-partum care, and that the patients are more inclined to place themselves under the care of their physicians early in pregnancy.

The hospitals are checking up their facilities for obstetrical care, and have posted the rules suggested by the committee. They are also keeping better records. They are commended for the promptness with which they have sent in their annual reports.

In 1938, 78 per cent of births were in hospitals; 18 per cent were delivered by physicians in the home; and four per cent were delivered by midwives in the home.

The maternal welfare work goes on largely

through the splendid coöperation of the State Department of Health, the physicians, hospitals, and nurses throughout the State, which is greatly appreciated by the committee.

Let us have more care in the normal cases, and more consultations and earlier in the abnormal cases, to make a new record for the coming year in maternal mortality statistics.

Respectfully submitted,

ARTHUR WALTER BINGHAM, *Chairman*
JOHN CARLISLE BROWN, *Vice-Chairman*
SAMUEL ALLISON COSGROVE
GEORGE BURTON GERMAN
CARL HALLER ILL
JULIUS LEVY
ROBERT ABBE MACKENZIE
WALTER BARCLAY MOUNT
JAMES HARRIS UNDERWOOD
HARRISON BETTS WILSON ..
THOMAS BENJAMIN LEE, *Consultant*

No report was received from the Advisory Committee on Mental Hygiene.

REPORT OF THE ADVISORY COMMITTEE ON PNEUMONIA CONTROL

By ROBERT ANTHONY KILDUFFE, M.D., Chairman, Atlantic City, N. J.

(Summary of the complete report filed in the Executive Office.)

To the Sub-Committee on Public Health:

The New Jersey program for the control of pneumonia was made possible by the passage of a bill introduced by Senator Taggart in the late Spring of 1938, appropriating \$25,000 for the distribution of antipneumococcus serum to patients whose private resources were insufficient to obtain it. The beneficiaries included the low-wage group, as well as the indi-



gent. The distributing agent was the State Department of Health, acting in coöperation with The Medical Society of New Jersey.

For the determination of the type of serum needed by the individual patients, 117 stations were set up in locations so distributed that one or more was within a reasonable distance of every doctor. The laboratories of hospitals and of private practitioners were approved and utilized so far as possible.

For the distribution of the type of serum required by any individual patients, twenty-nine stations were established, eleven of which were key stations carrying large stocks of all

the serums, and from which the smaller stations carrying only the more commonly used serums (Types I and II) could be replenished.

The State Department of Health in Trenton is the main serum station from which all supplies are stocked and replenished.

TYPES OF SERUM

Early in their deliberations the committee and the State Department had to decide upon the types of serum to be distributed. In view of the facts that the money available was limited, and that the therapeutic value of some of the serums was not definitely known, it was decided to distribute only the serums whose value was unquestioned. The distribution of free serum was therefore restricted to the following:

Horse serum of types I, II, V, VII, and VIII.

Rabbit serum of types I and III.

REQUIREMENTS

In order for a physician to obtain serum for a patient, he was required to conform to the following rules:

1. The sputum must have been typed in an approved laboratory.

2. The physician must certify that the patient does not have sufficient resources to secure the serum from commercial sources.

3. The physician must make a report of each patient on a blank form, giving the type of pneumococcus, the amount of serum used, the reactions and complications, and other information needed in judging the results of the serum.

EDUCATIONAL PROGRAM

The committee instituted the following program for educating the medical profession and the public regarding the typing and the serum. This program included:

1. Films were shown in ninety motion picture theatres.

2. Special programs and speakers on pneumonia were offered to medical societies, including both silent and sound films.

3. Newspaper publicity.

3. Notices, descriptions, and editorials were printed in *The Journal of The Medical Society of New Jersey*.

5. Letters and circulars of information were sent by the State Department of Health to practicing physicians.

6. Pneumonia was made a reportable disease.

7. Specimens of sputum submitted for typing were collected and examined in the State Laboratory at Trenton for two purposes:

a. To ascertain the type incidence of pneumococcal pneumonias throughout the State.

b. To check the efficiency of the sputum-typing laboratories throughout the State.

ing year. Conditions unfavorable to securing the appropriation are:

1. The stringent financial conditions throughout the country.

2. The publicity given to sulfanilamide and other chemicals in the treatment of pneumonia. The attitude of the committee is that both the serum and the chemical lines of treatment should be promoted.

The unusually low incidence of pneumonia during March has resulted in the conservation of the supply of serum.

RESULTS

The following data include the information available up to March 15, 1939, regarding the treatment of pneumonia patients with State serum:

Number of patients treated	690
Number of physicians using State serum ..	376
Number of completed reports	500
Recoveries	416
Deaths	84
Mortality rate, per cent	16.8

Among the 1,300 sputum specimens examined, 133 did not yield a specific pneumococcus typing by the Newfield method, and were typeable only after mouse inoculation.

The type incidence is shown in the following table:

Pneumococcus Type	State Serum Treated	Recovered	Died	Percent of Mortality	Estimated Mortality	Estimated Lives Saved
I	256	220	36	14	30	41
II	96	77	19	20	42	21
III (rabbit)	3	3	0	0	50	2
V	33	28	5	15	33	6
VII	37	26	11	19	25	5
VIII	55	42	13	23	35	6
Totals	500	416	84	16.8		81

APPROPRIATIONS

The initial appropriation of \$25,000 became exhausted late in the winter, but the good results obtained convinced the Legislature and the Governor of the wisdom of granting a further appropriation of \$25,000. A strong argument for the appropriation was the public-spirited attitude of the physicians throughout the State in coöperating with the Department of Health, and the demonstration of numerous lives saved by the use of the serum.

The Pneumonia Committee suggests that an appropriation of \$50,000 be made for conducting the anti-pneumonia work during the com-

COMMENTS ON THE ATTITUDE OF DOCTORS

Unfamiliarity with Typing.—Some physicians were uncertain or unfamiliar with the mechanism of the distribution and use of the serum, although the information has been published in *The Journal*.

The remedy would appear to lie not so much in education, as in reiteration.

Delay in Reporting.—While the final reports on treated cases were returned with a fair degree of promptness, there was sometimes a delay which was unnecessary.

Wastage.—Carelessness in using the serum was sometimes evident. For example, six ampules were returned to a distributing station

with two c.c. of serum withdrawn from each, without any explanation.

SUMMARY

The committee feels that, all things considered, the anti-pneumococcus campaign has functioned satisfactorily, and that definite re-

sults have been secured in a degree warranting the continuance of the project.

Respectfully submitted,

ROBERT ANTHONY KILDUFFE, *Chairman*
THOMAS MICHAEL KAIN
HENRY PAUL DENGLE
MARSHALL FLOWER LUMMIS
FREDERICK THOMAS VOSBURGH

REPORT OF THE ADVISORY COMMITTEE ON TRAFFIC ACCIDENTS

By ELBERT STETSON SHERMAN, M.D., Chairman, Newark, N. J.

To the Sub-Committee on Public Health:

Following the last Annual Meeting of The Medical Society of New Jersey, President Carington appointed an Advisory Committee on Traffic Accidents. The work assigned to the committee was to advise with the Commissioner of Motor Vehicles concerning any medical problems arising in the administration of his Department that he might desire to refer to the committee.



EXAMINATION FOR DRUNKENNESS

The Commissioner's first request was for the construction of a standard form to be used throughout the State by physicians when examining alleged drunken drivers. The form has been submitted, and after a slight modification has been accepted by the Commissioner. It is about to be printed and distributed.

PHYSICAL FITNESS

Commissioner Magee is interested in the subject of the mental and physical fitness of drivers. He informs us: "There is an increasing number of licensed drivers who are stricken with heart attacks, epileptic seizures, chronic high blood pressure and other serious ailments while at the wheel of an automobile (many of which attacks have resulted in death or injury to others)." He asks us to inform him just what ailments make a person unsafe and unfit to drive a motor vehicle; and he proposes, "When the medical profession is in accord on these ailments", to request legislation requiring the reporting of such cases to the Motor Vehicle Department, so that reasonable grounds may be established for prohibiting such persons from driving a motor vehicle.

PERIODIC EXAMINATIONS

In discussing the advisability of periodic re-examinations of drivers, the Commissioner has

propounded this question: "Does your committee believe that mental and physical coordination required for safe driving generally decreases to such an amount above a specific age to make it reasonable or advisable to compel periodic reexaminations? If so, at what age?"

The committee requests, and will be grateful for, opinions of members of the Society concerning these matters. They are too important to be decided hurriedly and without thorough study and careful consideration. Data on which to base such study was found to be very meager. In order to remedy the deficiency this committee, with the coöperation of the Motor Vehicle Department and with the aid of the Society's executive officers, has been investigating all cases of sudden death of automobile drivers. Such an investigation will necessarily take considerable time, but it is hoped that it can be continued until sufficient information is obtained to serve as a reliable guide for determining policies governing the issuing of drivers' licenses to persons whose mental or physical condition is a safety hazard.

CHEMICAL TESTS

Chemical tests of body fluids and of the breath for the determination of the degree of alcoholic intoxication to be used as evidence in cases of alleged drunken driving, is a subject which has recently been studied by various investigators. The committee has been giving this matter considerable attention, and has been kept informed of the latest developments concerning it.

The Commissioner of Motor Vehicles is giving much attention to the problem of injuries and deaths resulting from automobile accidents. He has expressed his appreciation of the interest and coöperation of the New Jersey State Medical Society.

Respectfully submitted,

ELBERT STETSON SHERMAN, *Chairman*
MILLARD FREEMAN SEWALL, *Vice-Chairman*
THOMAS SIMON PADDOCK FITCH
CHRISTIAN PETER SEGARD
GEORGE JOHN YOUNG
JESSE LYNN MAHAFFEY
WATSON BUDLONG MORRIS, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON TUBERCULOSIS

By ABRAHAM EZRA JAFFIN, M.D., Chairman, Jersey City, N. J.

To the Sub-Committee on Public Health:

The Committee on Tuberculosis, soon after its organization, devoted itself largely to the program of advocating methods for earlier case-finding. Your chairman has been fortunate in having the support of a body of men highly qualified for the task, and has enjoyed the benefit of not only their ripe experience, but also their hearty co-operation. The attendance has been almost 100 per cent at all meetings.



SURVEYS OF ADOLESCENT GROUPS

In many counties, case-finding by group surveys in high schools and colleges is well under way. Unfortunately, in some, there has been no action as yet; in fact, there is still opposition to the plan as a public health measure. There is great need for more education of the profession in these counties, in order to demonstrate the advantages of such surveys to not only the public, but also to themselves. Some members of this committee feel that our efforts are handicapped by the attitude of those in the profession that are least informed on the problem.

We would, therefore, again urge that the Committee on Post-Graduate Education establish courses for modern case-finding methods in all counties that have failed to develop plans for the same.

ADULT GROUPS

There is also a great need for efforts to reach adult groups, especially in the low-wage levels, and for advocating chest x-rays, with or without tuberculin tests, as a part of a periodic health examination in private practice.

CASE-FINDING IN PUBLIC SCHOOLS

The committee has also urged that all school personnel be required to have a chest x-ray periodically, as a protection to pupils and themselves.

All this has met with the hearty coöperation of Dr. Allen G. Ireland, State Director of

Health and Physical Education, who has submitted a very comprehensive questionnaire to your chairman on the subject *Tuberculosis Case-finding in Public Schools*.

With the valuable aid of the members of this committee, the answers to the questionnaire were carefully prepared, and submitted to the State Public Health Committee, who ordered them published in the State Journal (Feb., 1939, p. 109). Three thousand reprints of this article were then sent to Dr. Ireland for further distribution to proper agencies and persons throughout the State.

MANTOUX SKIN TEST

As a further aid to the physicians in the State, many of whom are not familiar with the Mantoux test, plans have been formulated for the publication of colored illustrations of the reaction in the Journal. The State Board of Health has also been requested to supply them with *tuberculin* on the same basis as other biologicals.

The committee has also arranged for practical demonstrations of the Mantoux test at the next State meeting in its scientific exhibit. Through the efforts of Dr. Clyde M. Fish, of Pleasantville, we are to have a practical demonstration of the Mantoux test daily, during the Annual Meeting, between 3 and 5 p. m. On successive days, Drs. English, Newcomb, and Runnells will have members of the staffs of their institutions present who will perform these tests. Dr. E. H. Nickman, of Atlantic City, will coöperate with members of this committee in supervising and aiding in this demonstration.

In closing, I wish again to express my deep appreciation of the very sincere and cordial coöperation of all the members of this committee. We have also enjoyed the frequent attendance of our Consultant, Dr. F. J. Quigley, whose interest has been stimulating and valuable.

Respectfully submitted,

ABRAHAM EZRA JAFFIN, *Chairman*
SAMUEL BUDD ENGLISH, *Vice-Chairman*
NORMAN WYVELL BURRITT
LEO BERTHIER DRAKE
CLYDE M. FISH
MARCUS WARD NEWCOMB
HAROLD SIMON HATCH
JOHN EDMUNDS RUNNELLS
HARRY BURTON WALKER
FREDERIC JAMES QUIGLEY, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON VENEREAL DISEASE CONTROL

By CHARLES BYRON BLAISDELL, M.D., Chairman, Long Branch, N. J.

To the Sub-Committee on Public Health:

At the inception of the 1938-1939 program, the Advisory Committee on Venereal Disease



Control had four points offered for its consideration, as follows:

1. Clinic extension. Since 1936, when thirty-six clinics were in operation in New Jersey, there are now sixty-four.

2. Free drug distribution. This has been made equally and easily available for

doctors and some clinics. Approximately \$6,000 was spent prior to 1936; whereas, approximately \$25,000 is now being expended.

3. Appointments of the doctors for new clinics. This has been left to the county medical societies' recommendations, coming from their own Venereal Disease Committees. The arrangement, developed mutually with the State Bureau of Venereal Disease Control and the public health officers, has resulted usually in unquestioned acceptance of the medical societies' recommendation. In some cases, for the purposes of harmony, it has been further expedient, first, to have more than one medical name offered for a given clinic position; and, secondly, to agree that the appointee must be mutually acceptable to the health officers, the State Bureau, and the Medical Society. In all cases, it seems best to offer more names than positions to be filled, and urge upon the State Bureau of Venereal Disease Control the societies' preference, but be willing to adjust differences of opinion.

There are 145 doctors who are now serving in new and old clinics in New Jersey, of whom seventy-one receive some remuneration and seventy-four none, this latter because of the restrictions of many hospitals prohibiting remuneration for out-patient services. Approximately \$30,000 was received by doctors during the year 1938.

4. Reporting venereal disease by name or number. This has been left to the discretion of the State Department of Health without rec-

ommendation since it is most immediately interested in vital statistics.

NEW PROJECTS

Three new projects were undertaken:

1. *To have each county appoint its own Venereal Disease Committee.* Chairmen have been appointed, and these committees are increasingly serving their local societies in handling the county venereal disease problems. This applies to all but a few counties.

2. *Education.* More information has been sent individually to all doctors' offices in the form of pamphlets on comprehensive treatment and diagnosis; in the form of reports or papers in the Journal; and in the provision of refresher courses in venereal disease diagnosis and treatment given under the auspices of the State Department of Health. These were conducted in Philadelphia under the direction of Dr. John Stokes, and in the Orange Memorial Hospital under the direction of our late friend, Dr. Robert Sellers.

Twenty doctors attended the Philadelphia courses, and thirty the Orange Memorial course. In addition, courses were made available to nurses for increasing their proficiency in venereal disease work.

3. *Continued coöperation* with the State Department of Health and the Public Health Officers' Association. This has been carried on at each meeting, when representatives from the State Bureau of Venereal Disease Control were always in attendance. In many instances, we could be of immediate value in an advisory capacity, and have been able to consider with them such matters as the operation of the premarital and prenatal bills, to appeal to the Legislature's Appropriations Committee for maintaining the laboratory services, for advising on a reasonable fee for examinations made obligatory by law, and for setting up a method of treatment and case finding in Sussex and Warren Counties on a provisional basis for one year. In addition, through representation, we have had an active part in the Sub-Committee on Venereal Disease of Governor Moore's New Jersey Health and Welfare Committee, and also the New Jersey Social Hygiene Association which is linked with the American Social Hygiene Association. Finally, we have co-operated with the Public Relations Committee in providing speakers at many meetings.

RECOMMENDATIONS

Our recommendations for the next year are:

1. To urge increased appropriations by the State and local communities to match Federal funds in extending the case-finding and treatment work which has already been so greatly increased. Costs of the 1938 program have been as follows:

Local—\$147,000.

Federal—\$71,000 (La Follette-Bullwinkle Bill of 1938).

State—\$26,000.

The Federal grant will be doubled this year, calling for additional matching funds raised within the State, which should be a great help in widening the scope of the work and strengthening the personnel.

2. *Education.* Figures indicate that one-half of our membership treat some venereal disease cases occasionally. Reports still come in indicating a non-adherence to what is acknowledged sound treatment. Members are urged to acquaint themselves accurately with these sound principles of treatment, or refer patients to doctors doing more of this work. Prospective and present appointees for work in clinics should apply through their County Venereal Disease Committees for appointments to the courses previously mentioned, as it is probable that more openings will exist this year in the refresher courses.

3. *Continued coöperation* with the State Department of Health and Public Health Officers' Association, and a consideration with them of measures designed to increase case finding, control centers of infection, help nurs-

ing organizations standardize and extend their work, and devise methods and means for correlating the services of doctor, nurse and health officer, to provide better and increasingly skillful service to all population groups. In 1936 there were 243,704 treatments given in clinics, whereas in 1938 they had risen to 403,371. We feel this is a very tangible indication of the increased efficiency in attacking the syphilis problem in New Jersey, and believe that it is largely the result of the stimulating coördination of the work of the health agencies.

ACKNOWLEDGEMENTS

1. To Dr. J. Lynn Mahaffey, Mr. William MacDonald, and the State Bureau of Venereal Disease Control under Dr. Karl M. Scott, for their unfailing willingness to discuss and adjust all problems that have arisen.

2. To the Public Health Officers' Association, whose energetic Chairman of the Venereal Disease Committee, Mr. L. Van D. Chandler, has been willing to consult and advise on many occasions.

3. To the Medical Practice Committee and Public Relations Committee, and to numerous heads of nursing, lay, and county administrative organizations, we acknowledge our indebtedness, and voice our appreciation of the help they have given us.

Respectfully submitted,

CHARLES BYRON BLAISDELL, *Chairman*
MARSHALL DAVIS HOGAN
BAXTER ALFONSO LIVENGOD
STANLEY MARTIN MCGEEHAN
ROBERT RAYMOND SELLERS
STANLEY R. WOODRUFF
WILLIAM FRANCIS COSTELLO, *Consultant*

REPORT OF THE SUB-COMMITTEE ON PUBLIC RELATIONS

By JOSEPH HENRY KLER, M.D., Chairman, New Brunswick, N. J.

To the Welfare Committee:

In its annual report for the year 1937-1938, the Sub-Committee on Public Relations listed two objectives for the year 1938-1939 (Jour., May, 1938, p. 305):



1. To carry medical instruction to the people in simple terms which they can understand.

2. To inspire them to support and apply the public health measures which are pro-

posed by the medical societies of the State and the counties.

The following is a report of the committee's activities in its efforts to fulfill those objectives.

The annual report for 1938 included a résumé of the previous year's work of the committee up to the annual meeting. A brief résumé of the committee's efforts to publicize the 1938 annual meeting is therefore included, to assure a complete report of activities from year to year.

PUBLICIZING THE 1938 ANNUAL CONVENTION

The Sub-Committee on Public Relations sent out four general news stories for statewide release on the annual convention,—one a week during the month of May, 1938. All daily and Sunday papers were provided with programs and copies of the annual reports. Special press releases were sent to newspapers in communities which were represented by physicians on the scientific program. These releases were based on extracts from the speakers' talks which would be of interest to the general public.

A total of at least 142 news stories pertaining to the 1938 annual convention appeared in sixty-one different newspapers, fifty-two of which are published in New Jersey.

The committee supervised the creation of an exhibit displayed at the annual convention which was intended to show the contributions of different organizations and agencies, both official and voluntary, to the total health care of man.

The chairman of the committee delivered three radio talks, one each day of the conven-

tion, over station WPG, explaining the organization and functions of the Medical Society, and pointing out how its activities were inseparably interwoven with improved health for all the people of the State.

With the advent of the new administration the committee continued, with modifications, the general program of public relations which had been evolved during the previous year, 1937-1938.

EMPHASIS OF COUNTY MEDICAL SOCIETIES

The committee has not been insensible to the desirability of securing recognition of county medical societies as advisers of county and community organizations in matters having health or medical significance. During the course of the year a suggested program of public relations for county medical societies was outlined by the committee. (Journal of The Medical Society of New Jersey, October, 1938, p. 630.)

The distribution of the weekly health feature, "The M.D. Says:", has been turned over to county medical societies as a part of the committee's program to foster public recognition of the component units of the State Society. This feature is prepared by the committee and sent each week to the county medical societies for distribution to the press in each county. This feature has been sent out each week without fail since the first week in November, 1937. Most physicians of the State have probably seen it at one time or another in their local paper. For those who have not, it may be said that it is a concise feature dealing in general principles of healthful living with a scrupulous avoidance of anything that might be objectionable to physicians. This feature is a good form of routine publicity, and it has been published in every county in the State.

The committee has also prepared other publicity material, such as press releases, at the request of county medical societies.

PRESS RELEASES

Twenty-nine news releases have been sent to the Press since the 1938 annual convention. This is better than an average of one every two weeks. Some of these releases have been reports of Society activities, as in the case of the *Fall Clinical Conference*. Others have been in the nature of feature articles, with a timely or seasonal emphasis. Much attention has been

devoted to the presentation of the Society's position on *medical economics*. A copy of each release is sent to every New Jersey legislator at Trenton and Washington, and to representatives of numerous organizations,—farm, labor, women's clubs, etc.,—in an effort to provide these groups with first-hand information concerning the Medical Society.

A list of releases sent out during the year (up to the time this is written) follows:

1. May 21, 1938—Two labor organizations' endorsement of the Medical Society's plan (E. R. A.) for 'caring for indigent patients.
2. May 27, 1938—The Society's survey of medical facilities.
3. June 3, 1938—"Short Fillers"—brief paragraphs about Society activities—sent to the press.
4. June 10, 1938—Summer health suggestions.
5. June 17, 1938—President Carrington's statement about LaFollette-Bulwinkle bill, and warning against quackery in the treatment of syphilis.
6. June 24, 1938—President Carrington's address to the New Jersey Pharmaceutical Association advocating a coöperative plan of medical care.
7. July 1, 1938—"Dog Days."
8. July 8, 1938—Invitation to all persons in New Jersey who are unable to obtain medical care to register at Executive Offices of the State Medical Society.
9. July 16, 1938—The 172nd anniversary of the State Society.
10. July 22, 1938—"Short Fillers."
11. Aug. 5, 1938—The medical economics policies of The Medical Society of New Jersey.
12. Sept. 23, 1938—President Carrington's analysis of the National Health Conference.
13. Sept. 23, 1938—The Fall Clinical Conference.
14. Oct. 7, 1938—Press release reporting response of invitation to the public to register if unable to obtain medical care.
15. Oct. 14, 1938—National Pharmacy Week.
16. Oct. 21, 1938—The Society's anti-appendicitis program.
17. Oct. 28, 1938—"Short Fillers."
18. Nov. 4, 1938—Tularemia. Release timed to coincide with the opening of the rabbit hunting season.
19. Nov. 4, 1938—First press release on Fifth Councilor District Meeting.
20. Nov. 11, 1938—Press release on meeting of Third Councilor District.
21. Nov. 15, 1938—Second press release on meeting of Fifth Councilor District.
22. Dec., 1938—Press release on meeting of Fourth Councilor District.
- 23 & 24. Dec., 1938—Two press releases on meeting of Second Councilor District.
25. Jan. 6, 1939—Pneumonia.
26. Jan. 20, 1939—Social Hygiene Day.
27. Mar. 3, 1939—Releases on the Medical Practice Bill, A-210.
28. April 11, 1939—Press release on A-210.
29. April 12, 1939—Press release on A-210.

REPRINTS AND REPRODUCTIONS

From time to time the committee has sent to the press and to its mailing list, reprints or mimeographed copies of material which illustrates the stand of the Medical Society on various matters, particularly with reference to medical economics. A list of such material which has been sent out during the last year follows:

1. July 11, 1938—Mimeographed copies of editorial which appeared in the Milwaukee Journal June 26, 1938, commending physicians on their opposition to state medicine,—sent to all New Jersey legislators, Governor Moore, representatives of various organizations, etc.
2. Aug. 19, 1938—Reprint of article by David Lawrence, Washington newspaper columnist, on U. S. Department of Justice action against the Medical Society of the District of Columbia and the American Medical Association,—sent to all New Jersey legislators, etc.
3. Sept. 23, 1938—Dr. Carrington's analysis of the National Health Conference,—sent to the press, and to a mailing list.
4. Nov., 1938—Copies of Dr. Haven Emerson's analysis of the National Health Conference,—sent to the press and mailing list.
- 5 & 6. Mar., 1939—Reprints of two editorials favorable to Assembly Bill No. 210,—sent to the press, legislators, etc.
- 7 & 8. Mar., 1939—Reprints of two signed newspaper articles favorable to A-210 sent to press, legislators, etc.
9. Mar. 16, 1939—Committee's analysis of A-210,—sent to press and legislators, etc.
10. April 12, 1939—Reprints of excerpts from publication of Committee on Costs of Medical Care on "Chiropractic".

LETTERS

1. June, 1938—Letter sent to New York Herald-Tribune pointing out misleading generalizations which appeared in an article in the paper's magazine section in a Sunday issue.
2. Oct., 1938—Letter on appendicitis program—sent to every school physician in New Jersey.
3. Nov., 1938—General letter on health aims prepared for the Auxiliary.
4. Nov., 1938—Letter publicizing the meeting of New Jersey Welfare Council,—sent to numerous physicians, county medical society secretaries, etc.
- 5 & 6. Mar., 1939—Two open letters relating to A-210,—sent to the press and mailing list.
7. March, 1939—At least a dozen letters, signed by chairman of committee, were written in reply to editorials against A-210.
8. April 1, 1939—Third open letter on A-210 was sent to press of State and to mailing list.

RADIO

May, 1938—As noted above, the chairman of the committee delivered three radio broadcasts over WPG during the annual convention.

July, 1938—Rad'o time secured and speaking arrangements made by committee for observance of 172nd anniversary of the Medical Society. Officers of the Society spoke over eight radio stations.

March, 1939—Participation of medical speakers in thirteen broadcasts on radio program of Rutgers University Homemakers' Forum arranged by committee.

ARTICLES IN MAGAZINES AND JOURNALS

Seven articles were prepared for publication in *Contemporary Life*.

Four articles were prepared for publication in *Health Progress*.

One article was prepared for publication in *New Jersey Educational Review*.

Six reports were prepared for publication in the *Journal of the American Medical Association*.

Seven reports of the committee's work have been written for the *Journal of The Medical Society of New Jersey*.

Three articles were prepared for publication in County Society Bulletins.

EXHIBITS

May, 1938—Exhibit arranged by committee for display at annual convention.

Nov., 1938—Committee arranged exhibit for meeting of New Jersey Public Health and Sanitary Association, Berkeley-Carteret Hotel, Asbury Park.

PROPOSED PAID ADVERTISING PROGRAM

In October, 1938, the committee proposed that county medical societies consider the feasibility of a series of newspaper advertisements to supplement the regular publicity of the Society in acquainting the public with the purposes and work of the societies. It is no exaggeration to say that great progress has been made in interpreting the medical profession to the public. The medical profession is, however, the target of consistent attacks, and much remains to be done in building good will. The medical profession must present its case to the public if it wishes to continue to enjoy public confidence. Newspapers refuse to print any great amount of information presenting organized medicine's position on medical economics in their news columns, on the ground that it is not "news" but material calculated to benefit the profession economically, and that it is therefore advertising. Institutional advertising therefore appears to be desirable, in order to supplement the Society's other public relations efforts.

The committee's proposals created widespread interest among newspaper publishers, and the Society received much publicity. *The Editor and Publisher*, leading trade journal of the newspaper world, featured the proposal. Requests for more information from various

parts of the United States indicate that the proposed advertising program received much publicity throughout the country.

A suggested list of newspapers for coverage of each county, and an estimate of costs were prepared by the committee for each county medical society. The Bergen and Passaic County Medical Societies have approved the paid advertising program. In Bergen County the Society is financing it with the use of funds from the Society treasury. In Passaic County the program is financed by levying a special assessment on the members of the Society.

PAMPHLETS ON MEDICAL ECONOMICS

Two pamphlets entitled "On the Witness Stand", and "Compulsory Health Insurance and Disease Control", which present the medical point of view with respect to medical economics, were sent to all newspapers, legislators, and others in the year 1937-1938. This year copies of these pamphlets were sent to every public library in New Jersey, and copies of them were also distributed among members of the Contemporary Club.

APPENDICITIS PROGRAM

The committee conducted the Society's second annual campaign to reduce the mortality rate of appendicitis. A letter explaining the program was sent to every school physician in New Jersey. Sixty thousand stickers were apportioned among the school physicians for distribution to school children in the upper grades. A press release explaining the program was sent to every paper in New Jersey. The committee had appendicitis placards printed for every pharmacy in New Jersey, and these were sent to the pharmacies by the New Jersey Pharmaceutical Association.

FALL CLINICAL CONFERENCE

The first annual Fall Clinical Conference was publicized by the committee. A press release was sent to every newspaper in New Jersey. Newspapers in Essex County and all daily papers were supplied with programs. The committee designed and had printed a placard which was sent to every hospital in New Jersey to publicize the Conference among physicians. Following the Conference, the committee checked the attendance to enable the Editor to publish a report in the Journal.

SPEAKERS' SERVICE BULLETINS

Three bulletins were added to the list of Speakers' Service Bulletins during the year, bringing the total number to eighteen.

LOAN MATERIAL

Material from the committee's extensive files of Loan Material have been loaned to numerous physicians during the year for their use in preparing talks to lay groups and also in preparing county society publicity. The committee has available five types of loan material:

1. The Speakers' Service Bulletins consisting of prepared talks and press releases on various subjects.
2. The Hygeia Loan Collection consisting of about fifty packages containing material from Hygeia magazine classified according to subject.
3. Radio Talks, a file of approximately 500 mimeographed radio talks, classified according to titles.
4. Technical file, consisting of 150 packages of material from Journals of the American Medical Association and other professional journals classified according to subject matter.
5. A file of material on medical economics.

PROPOSED PROGRAM FOR 1939-1940

It is suggested that the present program of the Public Relations Committee be continued during the coming year. This will include:

1. Press releases providing news of the Society's aims, activities, accomplishments, and other information relevant to health and medical care.
2. Continued sending of the weekly health feature, "The M.D. Says:", to the press.
3. Distributing to legislators and to mailing list, material pertaining to the work of the Society, and to the Society's position on medical economics.

4. Conducting a third annual anti-appendicitis campaign.

5. Exhibits.

6. Securing radio time for special occasions and promoting a Society radio program, if feasible.

7. Continued service to physicians in providing speakers' service loan material.

8. Continuing its function as service agency by assisting county medical society public relations committees in the preparation of publicity.

9. Continuing its contact work with the press and other organizations interested in health.

In addition to these routine activities the committee recommends:

1. Re-consideration of the proposed paid advertising program by county medical societies.
2. A meeting of the State Society's Public Relations Committee, with chairmen of county medical society public relations committees in order to coordinate and clarify public relations policies of the State and county societies.
3. Preparing and distributing to physicians concise information pertaining to medical economics. Medical economics will continue to be a popular subject of public discussion until the economic situation of the country improves. When times are good, most people are not interested in socialized medicine. The cost of medical care looms larger, however, when times are bad. It is important for physicians to acquaint themselves with various phases of the problem.

Respectfully submitted,

JOSEPH HENRY KLER, *Chairman*
JOSEPH BERKELEY GORDON, *Vice-Chairman*
GEORGE BARTON BARLOW
EDGAR PARMELE CARDWELL
HOMER ISAAC SILVERS
JACOB ALLEN YAGER
ELIAS JOSEPH MARSH, *Consultant*

PART THREE

REPORTS OF PRESIDENTS OF COUNTY SOCIETIES

REPORT OF ATLANTIC COUNTY MEDICAL SOCIETY

By JAMES HENRY MASON, M.D., President, Atlantic City, N. J.

To the House of Delegates:

I am enclosing reports from the chairmen of the more important committees in the Atlantic County Medical Society. These reports give a brief but concise statement of the various activities of our society during the past year.

Regular monthly scientific and business meetings have been held once a month throughout the year.

The chairmen of the different committees have been most coöperative, and have accomplished very satisfactory results.

TUBERCULOSIS

By Clyde M. Fish, M.D., Chairman

During the past year the Tuberculosis Committee has promoted the Mantoux test in children of school age. Our guest speakers, Dr. B. S. Pollak, of Jersey City, and Dr. Lawrence Flick, of Philadelphia, created an interest that has resulted in the test being given in the schools throughout the county, with a careful x-ray follow-up, which is going on at the present time.

We have every reason to believe that through the efforts of the county society, before another year has passed, tuberculin testing will reach a very high average of the pupils in every school in the county.

PUBLIC HEALTH COMMITTEE

D. W. Scanlan, M.D., Chairman

The Public Health Committee nominated candidates for the positions of Field Physician, and also to serve in the Baby Keep-Well Station for colored babies.

The county society formulated rules for visiting nurses which were accepted by the Visiting Nurse Association.

Some difficulties between a few physicians and the local field nurse for pre- and post-natal instructions were ironed out by meetings with the nurse and complaining physicians.

A method of caring for indigent emergency sick calls was arranged at a conference with

the Mayor, the Health Officer and other officials.

The county society supplied examining physicians daily to the health examination booth at the Atlantic County Fair at Egg Harbor in September.

GRADUATE EDUCATION

Clarence L. Andrews, M.D., Chairman

The committee has arranged a course of six evening lectures at a cost of eight dollars per member enrolling.

March 21—Serum Therapy and Chemotherapy—Dr. H. A. Reimann, Jefferson Medical College, Philadelphia.

March 28—Obstetrical Complications—Dr. C. B. Lull, Jefferson Medical College.

April 4—Office Gynecology—Dr. L. C. Schefey, Jefferson Medical College.

April 11—Minor Office Surgery—Dr. W. E. Burnett, Temple University.

April 18—General Pediatrics—Dr. R. M. Tyson, Lying-In Hospital, Philadelphia.

April 25—Fractures—Dr. N. W. Cornell, Cornell Medical College, New York.

CANCER CONTROL

By William O. Roop, M.D., Chairman

The Cancer Control Committee has been co-operating with the State Cancer Control Committee by having a representative of the local committee attend the meetings of the State committee and carrying out the suggestions of the State Cancer Control Committee in Atlantic County, aiming particularly to make both the physician and the public cancer-conscious.

At the suggestion of this committee, the monthly meeting held March 10th was devoted entirely to the consideration of cancer. The speaker on this occasion was Dr. William G. Herrman, Chairman of the State Cancer Control Committee.

Also this committee is sponsoring articles on the subject of cancer which are being published occasionally in the Monthly Bulletin of this society.

VENEREAL DISEASE CONTROL

By Leland S. Madden, M.D.
Pleasantville, N. J.

There are four clinics treating venereal diseases in Atlantic County. A clinic in the Atlantic Shores Hospital at Somers Point, treating both gonorrhea and syphilis, reports progress. It was started the last part of 1938.

A clinic held in the asylum at Northfield, in charge of Dr. Infield, treating syphilis only, gives about fifty treatments weekly.

A clinic held once weekly in Mays Landing, headed by Dr. H. S. Hudson, and recently reorganized, treating only lues, is giving between fifteen and twenty treatments weekly.

Hammonton is making some arrangements to open a clinic in that city.

The Atlantic City clinic, out-patient venereal department of the genito-urinary service of the Atlantic City Hospital, held five days weekly at the Municipal Hospital with Dr. Bossert in charge, treating both gonorrhea and syphilis, gave 13,601 treatments from March 1, 1938, to March 1, 1939.

The follow-up work for the clinics has been very thorough.

There has been distributed much venereal literature throughout the county, and numerous articles have been published in the newspapers.

A number of talks to organizations have been made by several physicians.

PUBLIC RELATIONS COMMITTEE

Charles B. Kaighn, M.D., Chairman

Your Public Relations Committee has found its greatest field of usefulness in the supplying of speakers to various social and fraternal organizations through the Woman's Auxiliary. About twenty-five public addresses were made by eighteen members of the society. An effort was also made to emphasize the fact that their appearances before any group were as members of the organized medical profession rather than individuals. The health aims of this society were stressed, and our attitude toward the care of the indigent emphasized. With but few exceptions, the members responded readily to the request to speak.

The question of one member of the society indulging in an advertising campaign was brought before the committee, who referred it to the Board of Censors.

COMMITTEE ON LEGISLATION

David B. Allman, M.D., Chairman

Your Committee on Legislation wishes to report that we have been actively engaged since our appointment in endeavoring to foster such favorable legislation as has been presented and in working against any unfavorable legislation.

The Chairman of the Committee on Legislation has kept in close contact with the Chairman of the Legislation Committee for the State of New Jersey; and because of my position as Key Man of Atlantic County for the State, we have been able to proceed with our work with celerity and efficiency.

The Legislative Bulletins which are released by the State Executive Offices at frequent intervals have been carefully scrutinized, and action has been taken in all important matters.

By far, of course, the most essential of the bills is Assembly Bill No. 210—The Uniform Medical Practice Act. In addition to personally contacting our three Legislators concerning this bill, the members of the county society have had their patients mail in approximately 1,000 postal cards to each Legislator requesting their energetic support of this bill.

We are extremely fortunate in Atlantic County in having as our representatives three highly intelligent gentlemen who are at all times open to reasoning, and who in the past have enthusiastically supported organized medicine and who in the future, I am sure, will continue to support us if our demands are just and reasonable.

ENTERTAINMENT COMMITTEE

Edward F. Uzzell, M.D., Chairman

The Entertainment Committee of the Atlantic County Medical Society, of which I am Chairman, is actively planning to have an outing at some place that will be chosen by the majority of the members or the committee. The location and date will be announced later.

REPORT OF THE BERGEN COUNTY MEDICAL SOCIETY

By CHESTER A. KING, M.D., President, Oradell, N. J.

To the House of Delegates:

The Bergen County Medical Society has had a successful and progressive year. The meetings have been well attended and the members

have shown a deep interest in the proceedings, both business and scientific.

All committees have been active. They have held numerous meetings and have been completely coöperative with the officers.

Through the *Membership Committee* the enrollment has increased in number, though there have been three transfers, and two leaves of absence.

The *Ethics Committee* has had a number of cases before them during the year which have been amicably settled.

The *By-Laws Committee* will have completed, by the end of the year, the revision of the Constitution and By-Laws.

The *Scientific Committee* has furnished the scientific programs throughout the year which have been very interesting and instructive. These programs have covered a variety of subjects, including "Use and Abuse of Sulphanilamide", "Diagnosis and Treatment of Syphilis", "The Pneumonias", "Recent Developments in the Diagnosis and Treatment of Low Back Pains and Sciatica with Special Reference to Herniations of the Nucleus Pulposus", "Background and Newer Aspects of Coronary Diseases", "Medical Legal", "Communicable Diseases", and "Maternal Welfare".

The *Post-Graduate Committee* ran a course of six lectures which were very successful, on Dermatology for the General Practitioner.

The *Legislative-Welfare Committee* has been active. It has kept the Executive Committee and the members well advised on legislation, and has been behind general movements of the whole society toward the passing of medical legislation.

The *Public Relations Committee* is again, this year, publishing a newspaper edition on medical problems in public health, followed by a *Public Health Week* of even better programs than the one held by this committee last year. This committee has also had under its direction six sub-committees for the purpose of planning and arranging the Public Health Week, all of which having worked together, completed the program for the Public Health Week.

The *Public Health Committee* has put forward plans to The Medical Society of New Jersey for the care of the indigent and the medically indigent by the coöperation of the State Department of Health and The Medical Society of New Jersey, and coming down through to the county committees similarly constructed. This, of course, was with the idea of coming to the State Department of Health for financial aid for the medical care of the indigent, through the United States Public Health Service. It has further coöperated with the Public Relations Committee and the Public Health Week.

The *School Physicians Committee* has made progress in the examination of school children,

particularly along the lines of "Stripped to the Waist" examination.

The *Public Health Nursing Committee*, finding that the various nursing services of the county were working under different rules and regulations, has brought them together, and has managed to have them working now under one set of rules and regulations, coöperating together to the fullest extent.

The *Maternal Welfare Committee* has started an extensive plan which is progressing well, but which will take several years to round out and perfect.

The *Venereal Disease Committee* has made up and published a very complete report for physicians to follow in their treatment of venereal disease, giving with it reactions and how to avoid them.

The *Mental Hygiene Committee* has assisted in and worked along those lines, coöperating with the County Welfare Boards and other such institutions.

The *Tuberculosis Committee* has been coöperating with other agencies in applying the Mantoux test, and x-raying the high school scholars, teachers, and employees of the schools throughout the county.

The *Cancer Committee* has managed to set up in Bergen County an exact method of diagnosis and treatment of cancer and tumors which is being considered by the Governor's Committee on the Public Health of New Jersey as the ideal for cancer control.

The *Pharmaceutical Committee* has set up a very complete coöperative plan with the Bergen County Pharmaceutical Association.

The *Committee on Medical History* of Bergen County, under the direction of Dr. W. L. Vroom, has done a great work researching in the files of various libraries and old minutes, back in the early seventies, and has made a very wonderful report.

The *Drunken Drivers' Examination Committee* has been working with the County and State Police for making a comprehensive examination for drunken drivers.

The *Committee on North Jersey Transit Plans* has been working in close coöperation with the Planning Commission.

The *Hospital Standardization Committee* has unified rules and regulations governing all clinics in the county for the entrance and treatment of patients.

The *Committees on Clinical Pathology; Medical Economics; Contract Practice; Workmen's Compensation; Pediatric; Cardiac; Pneumonia; and Traumatic and Orthopedic Conditions* have made preliminary reports and are working on a program which will take some time to perfect.

EXECUTIVE COMMITTEE

All the business of the society has been handled by monthly meetings of the Executive Committee, consisting of the officers and six past presidents. Enhancing this committee, the chairmen of the various committees make up the larger Executive Committee. By this method of organization, the chairmen are cognizant of all debates on subjects coming before the Executive Committee and of their

action. They also have voting power on all committee subjects. Naturally any matter coming before the Executive Committee which is necessary for action by the society is brought before the society at the following meeting.

The society, as well as the Executive Committee, has held regular monthly meetings throughout the year. Also the society has held two special meetings on special scientific subjects.

REPORT OF BURLINGTON COUNTY MEDICAL SOCIETY

By FREDERICK D. FAHRENBRUCH, M.D., President, Mount Holly, N. J.

To the House of Delegates:

The activities of the Burlington County Medical Society have been most gratifying in the past year through the coöperation of the various committees.

An important action was the modernization of our Constitution and By-Laws to conform more closely with those of the State Society.

JUVENILE DELINQUENCY

The problem of *juvenile delinquents* in the county was considered and approved, and our willingness was expressed to coöperate with other organizations to aid in selecting a psychiatrist to supervise this project if funds were available.

CANCER PATIENTS

The society also approved a State institution be established for the care and support of indigent, incurable cancer patients, thereby relieving

the respective counties of this responsibility.

VENEREAL DISEASE

Venereal disease control was studied, and the State program approved. New clinics were established in Burlington, Bordentown, and Moorestown; and two other clinics were already in operation at the Burlington County Hospital, and the Zurbrugg Memorial Hospital, both being approved.

BABY KEEP-WELL STATION

New Baby Keep-Well Stations were organized at Riverside, and Delanco, and other stations already carrying on this work at Mount Holly, Beverly, and Maple Shade.

The W. P. A. Nursing Project was studied, and approved with certain recommendations.

Our society is endeavoring to keep abreast with all problems; and it pledges its coöperation with the other component societies to the State Society.

REPORT OF THE CAMDEN COUNTY MEDICAL SOCIETY

By H. WESLEY JACK, M.D., President, Collingswood, N. J.

To the House of Delegates:

In making a report of the work accomplished during the past society year of 1938-1939, for the County of Camden, the officers are pleased to record that we have had the utmost coöperation between all the committees and members of the county society; and that there has existed a high degree of enthusiasm and a willingness to work and to endeavor to accomplish any goal that was desired.

ATTENDANCE AT MEETINGS

We have had a definite increase in the monthly attendance of our meetings this year, for which we wish to give due credit to the excellent scientific programs produced by the Scientific Committee. It was of sufficient interest to increase the average attendance of each meeting by over twenty members beyond that of previous years. An all-time high point was reached at our January meeting, when we

were fortunate enough to have Dr. Frank Lahey, of Boston, address us.

COUNTY MEDICAL SURVEY

In the very beginning of the past year, the capable work of our *Committee on the Survey* of Camden County, with the various questionnaires, enabled Camden to be one of the earliest counties to report the fulfillment of this complete survey. At this same time, the Membership Committee, in conjunction with the Survey Committee, made a personal contact with every doctor within the county, placing before him the advantages of belonging to the County and State Society and soliciting his membership. This resulted in an increase in our membership of eighteen new members. Thus we are rated as having 183 active and paid-up members by March 15, 1939.

PUBLIC RELATIONS

The Public Relations Committee has functioned well, having contacted every newspaper within the county, and secured the insertion of timely bits of news of public interest. Likewise they have supplied speakers for the various organizations throughout the county to ethically disseminate knowledge of medico-surgical character.

MATERNAL WELFARE

We are particularly proud of the fact that the Maternal Welfare Committee has established a Maternal Death Conference; and that in conjunction with the Counties of Burlington and Gloucester, this Conference will be held monthly for the purpose of discussing the problems of Maternal Welfare and further aiding in the decrease of the mortality rate for the county concerned. This Conference is modeled and conducted after the manner of that of the Philadelphia County Maternal Welfare Society Conference, which has been so enthusiastically accepted by the medical profession.

GRADUATE EDUCATION

We again had our Post-Graduate Lecture Course this year, consisting of six lectures, all upon subjects of keen interest and rendered by most capable men. These lectures, as always, were well attended by the medical profession.

LEGISLATION

We are pleased to report that the Legislative Committee, with a keen man in this county, capably contacted the Legislators of Camden County and secured their able support for the Medical Practice Bill, A-211.

MEDICAL RELIEF

It was a definite accomplishment that a committee of the society contacted the E. R. A. authorities and secured a return of all ambulatory cases to the family physician, thus relieving the hospitals of this burden. And likewise the committee for the investigation or inquiry relative to inadequate medical care for people of the County of Camden made this investigation by personal contact and secured an adjustment of all needy cases.

CANCER

The county society is particularly pleased over the fact that the two general hospitals within the county have each established a Cancer Clinic, which is now functioning and endeavoring to render a high degree of efficient service in this most needy field.

The County Society was also very glad to give their whole-hearted endorsement to Mrs. A. Haines Lippincott, the Commander of the Field Army for the Control of Cancer, in her endeavor to enlist people of the State of New Jersey to disseminate knowledge and education concerning this disease.

OUTING MEETING

In Camden County we have two more meetings, namely that of May, when the officers for the coming year will assume their new duty. Likewise in the month of June, when we hold an outing at Tavistock Country Club, for the enjoyment of all the members, where they participate in athletic sports of golf, tennis, and trap shooting, with a pleasant evening's program.

NECROLOGY

The society has mourned the loss of two of its oldest members during this past year, Dr. McAllister, and Dr. Ross.

THE FUTURE

Many of the members of the County Society have participated in the active work of the State Society throughout this whole year. Thus we believe that the County Society of Camden is alive and awake to the present need of the medical profession, and is endeavoring to assume its rightful responsibilities within this county, and to discharge these duties in a capable, efficient and ethical manner.

We look forward to the year 1939-1940 as being one of the most active and best years that this society has ever had. We offer the incoming officers our whole-hearted support, and assure them of our willingness to be of service in their behalf throughout the coming year.

REPORT OF THE ESSEX COUNTY MEDICAL SOCIETY

By DAVID A. KRAKER, M.D., President, Newark, N. J.

To the House of Delegates:

During the current year the Essex County Medical Society, as a result of the very efficient efforts of its Membership Committee, and the whole-hearted coöperation of the society as a whole, has increased from March 15, 1938, from 842 active members and seventy-two associate members, to 942 active members and fifty-three associate members, making a total membership at this time of 995.

FALL CLINICAL CONFERENCE

At the request of Dr. William J. Carrington, President of The Medical Society of New Jersey, a committee was appointed by President Kraker, under the chairmanship of Dr. William Gauch, to arrange for a Clinical Conference of The Medical Society of New Jersey on October 6th and 7th. Due to the activity of the Chairman, Dr. Gauch, and his committee, and the coöperation of the Medical Boards of the Hospitals of Essex County, as well as the individual services of members of the Essex County Medical Society, a successful Conference was held throughout the hospitals. Particularly well attended was a lecture and demonstration at the Academy of Medicine of Northern New Jersey given by Dr. Harrison S. Martland, of Newark. A dinner meeting on the night of October 6th was well attended, at which addresses were delivered by Dr. William J. Carrington, President of The Medical Society of New Jersey; Dr. George Draper, Associate Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University, New York; Dr. William Gauch, Chairman of the General Committee; and Dr. Kraker, who presided. This Clinical Conference, which was the first ever held during the fall of the year by The Medical Society of New Jersey, has created a precedent established by Dr. Carrington, and which it is hoped will be continued by his successors.

LEGISLATION

The whole-hearted coöperation of the Officers and the Council of the Essex County Medical Society during the past year has resulted in the continued development of Organized Medicine in Essex County. The individual effort of these gentlemen in the study of the problems now confronting the profession is demonstrating an increasing improvement in the relationship of the public and the medical profession.

Much time and effort have been put in the consideration of matters of medical legislation during the current year, and after numerous conferences with members of the Legislative Committee of the State Medical Society, finally resulted in the introduction of Assembly Bill 211, which a few days ago successfully passed the Assembly and is now in committee of the Senate.

INSURANCE

In June of 1938 the Council officially applied for a Group Life Insurance contract with the Columbian National Life Insurance Company of Boston, Massachusetts, which provided for insurance of the members of the Essex County group, providing applications were received from not less than 75 per cent of the total membership of the Essex County Medical Society on the day of application. In the beginning applications were received from over 600 of our members; but a deficiency of about seventy made it necessary to abandon this enterprise at this time.

PUBLIC RELATIONS

The Committee on Public Relations was very active; and under the guidance of Dr. Royal A. Schaaf it has been successful in improving the relationship of the medical profession to the public in general, by conferences and contacts with civic organizations, and the public press and groups affiliated; or in contact with problems relating to the public health and welfare.

ECONOMICS SURVEY

The Committee on Economics, under the chairmanship of Dr. Harry N. Comando, efficiently organized and completed the Medical Survey, directed by The Medical Society of New Jersey; and through sub-committees, directed research and studies into problems of economic interest to the membership of the society, resulting in many constructive recommendations.

HOSPITALS

The Hospital Committee, under the chairmanship of Dr. H. R. Van Ness, considered many problems relating to the hospitals of the county, which resulted in recommendations to the society as a whole, of benefit to both the hospitals and the profession.

BULLETIN

The Publication Committee, under the chairmanship of Dr. Henry C. Barkhorn, has increased the efficiency and the value of the Bulletin with the assurance that it will soon be self-sustaining. Under the editorship of Dr. Henry A. Davidson, it is becoming of great value to the members; and through its exchange with other societies, has received recognition as a medical journal throughout the country.

PUBLIC HEALTH

The Public Health Committee, originally under the guidance of the late Dr. Theodor Teimer, and following his death, under the active supervision of Dr. Charles M. Robbins, has offered a very practical consideration of subjects relating to the public health. At the February meeting of the society it provided a very practical program on pneumonia; addresses were delivered by Dr. Russel Cecil on Serum Therapy, and by Dr. Edgar Lawrence on Chemotherapy. The meeting was characterized by a very large attendance and valuable general discussion.

CANCER

The Cancer Committee, Dr. Edgar A. Ill, Chairman, in association with Dr. Asher Yaguda, provided the program for the March 9th meeting, at which time the following program was presented: The "Organization and Function of a Cancer Clinic" was discussed and illustrated by Dr. Arthur Caselli; "Surgery in the Treatment of Cancer" was discussed by Dr. E. W. Sprague; "Radiation Therapy in Cancer", by Dr. Milton Friedman; and "Dem-

onstration of Cancer Material Through the Episcopate", by Dr. Harrison S. Martland.

CHILD AND MATERNAL WELFARE

Under the chairmanship of Dr. Chester R. Brown of the Child Welfare Committee, and Dr. H. B. Kessler of the Maternal Welfare Committee, a study was made of the care of the new-born infant, and recommendations for the consideration of the several hospitals throughout the county of the care of the new-born infant were issued.

The Child Welfare Committee provided the program of the April 13th meeting, at which time a symposium on child care in Essex County was given as follows: "Care of the Newborn", Dr. Robert E. Jennings; "Pediatric Clinics", Dr. William Panitch; "School Physicians", Dr. William Nevius; "Immunization", Dr. David P. Evans; and "Child Welfare Publicity", by Dr. Harrold Murray.

ENTERTAINMENT

The Entertainment Committee, headed by Dr. Harrold A. Murray, acted as a Reception Committee throughout the Clinical Session of the State Medical Society, and arranged for the dinner. The success of this session was in great part due to the activity of this committee.

General activity was demonstrated by the chairmen and members of the other committees of the society, and satisfactory reports were rendered when questions were referred to them by the Council. Throughout the present year the members of the society demonstrated their desire to be informed as to the problems confronting the medical profession, and coöperated generally in their solution.

REPORT OF THE GLOUCESTER COUNTY MEDICAL SOCIETY

By WILLIAM E. CRAIN, M.D., President, Woodbury, N. J.

To the House of Delegates:

My report relating to the Gloucester County Medical Society of necessity must be short.

I am pleased to say the meetings of the society have been well attended during the year.

All the committees have functioned actively and well.

There has been a fine spirit of coöperation and outstanding harmony among the members.

We shall miss three active and valuable members who have died during the year—Dr. Marshall F. Lunmis, Dr. Elwood E. Downs, and Dr. I. W. Knight.

REPORT OF THE HUDSON COUNTY MEDICAL SOCIETY

By REEVE L. BALLINGER, M.D., President, Arlington, N. J.

To the House of Delegates:

It is with considerable pride that I submit this report of the activities of the Hudson County Medical Society for this past year.

Membership has increased over the previous year, and our members have taken a more active interest in both county and State medical problems. We have had speakers of prominence at each of our monthly scientific meetings. The subjects have been varied and of instructive interest to all members. There has been a marked increase in good fellowship among our members this past year.

Our *Monthly Bulletin* has been increased in size and improved in its appearance. By means of increased advertising in our Bulletin it is now becoming self-sustaining instead of a drain on our treasury each month.

Through our *Publicity Committee* our weekly Radio Health Programs over Station WAAT have had their most successful year since this program began. This fact is proven by the increase in our fan mail and mailing list.

Speakers—Each week we are receiving several hundreds of letters for requests of our weekly instructive talks. We have supplied more speakers this year for various occasions as civic organizations, Parent-Teachers Associations, etc., than we have in any previous year. We supplied speakers for "The Health Observance Week" conducted by the State Y. M. C. A. of Hoboken and Jersey City during the week of March 26th to April 1st, 1939. Our column "The Doctor Says:" is published in the five daily papers in our county.

Our *Committee on Post-Graduate Education* has arranged a course of eight lectures on

pathology to be given in May by Dr. Paul Klemperer, Pathologist of the Mount Sinai Hospital of New York.

Our *Legislative Committee* with its chairman, Dr. B. S. Pollak, who is Chairman of the State Society Legislative Committee, has worked hard in its efforts to have the proper attention given by our members to the various medical bills which have come up in the State this year.

Our *Medical Survey* conducted in the county this year showed the medical needs of the county to be adequately taken care of by the profession; and the hospital facilities of our county are certainly sufficient to care for the sick and disabled in our county. We can assure you there is no need for State Medicine in Hudson County.

The *financial* condition of our county society, as reported by our Treasurer, Dr. Henry Spence, is good.

In closing my report, I wish to extend my appreciation to the members of my Executive Committee for their invaluable aid in helping me guide the course of our Society this year. Also to the chairmen and members of the various committees, and the members of our society who have helped make the work this year so pleasant.

To the President of the State Society, my friend, Dr. W. J. Carrington, I owe a debt of appreciation for his advice and coöperation in helping me throughout the year.

Respectfully submitted,

REEVE L. BALLINGER, M.D.,
President of Hudson County
Medical Society, 1939.

REPORT OF THE HUNTERDON COUNTY MEDICAL SOCIETY

By BARCLAY S. FUHRMANN, M.D., President, Flemington, N. J.

To the House of Delegates:

I am pleased to submit a report of the Hunterdon County Component Medical Society for the year ending June, 1939.

We are a small society, meeting regularly only four times each year. This year we have found it necessary to hold several special meetings in order that we might discuss the several scientific and economic problems before the medical profession.

We have had a meeting devoted solely to the discussion of each of the following subjects:

Syphilis, Pneumonia, and Tuberculosis. At each of these meetings there has been discussed the legislative problems which have been before the society at the time.

Our membership has increased this year, and I believe every physician in the county is a member of some county society under the American Medical Association.

Nothing of outstanding mention has occurred in the Hunterdon County Society this year, but we have had a steady increase in attendance and enthusiasm all the year.

REPORT OF THE MONMOUTH COUNTY MEDICAL SOCIETY

By C. BYRON BLAISDELL, M.D., President, Long Branch, N. J.

To the House of Delegates:

The Monmouth County Medical Society received its charter from The Medical Society of New Jersey in 1816, and is one of the twenty-one component societies of the parent State Society. Its present membership is 137. Most of these are graduates of medical schools in the United States, only eight being from those of Canada or Europe. The largest individual group, seventeen, comes from Hahnemann in Philadelphia; Jefferson is next with twelve; Bellevue with nine; P. & S. Columbia, New York Homeopathic, Georgetown and University of Maryland, eight each; Howard has five graduates; P. & S. Baltimore and University of Vermont have four each; Syracuse, Harvard and Medical College of Virginia have three each. The rest are scattered, with one or two graduates.

STATISTICS OF MEMBERS

Age Groups—The average age for graduating from medical school is twenty-five and the age for becoming licensed to practice twenty-six, although it is interesting to note that those members in the age groups from forty-five and upward, in many cases, were licensed to practice at the ages of twenty-one, twenty-two, etc.

The following is a table of the age groups of our members by decades of practice:

From 25 to 35 years	40
35 to 45 years	49
45 to 55 years	27
55 to 65 years	12
65 to 75 years	9

Members of society 137

It is interesting to see here that eighty-nine members are under forty-five years of age, and forty are under thirty-five. This indicates the rapidity of the growth of the society in the past twenty years.

Types of Practice—Approximately one-half the membership, — sixty-eight doctors, — do general practice without qualification. General surgeons form the next largest group, fourteen in number, of whom nine are Fellows of the American College of Surgeons. The eye, ear, nose and throat group is next with eleven, of whom three are Fellows of the American College of Surgeons. There are eight psychiatrists; six obstetricians; and five pediatricians. Other groups having one or two each are insurance physicians, neurologists, neurological

surgeons, orthopedic surgeons, pathologists, urologists, roentgenologists. There are nine members who combine a specialty with general practice and one member combines roentgenology with physiotherapy.

It is recognized that in this county, which is a mixture of suburban and rural population, several of the above groups participate in a small but nevertheless definite amount of general practice occasioned by the type of population which they serve.

Hospital and Clinic Connections—Of the total 137 members, 115 are connected with hospitals, practically all in Monmouth County.

Clinics—The following number of members work in clinics:

Venereal	14
Tuberculosis	6
Well Babies	11

Thirty-two of the thirty-seven school physicians are members of this county society.

There are nineteen osteopathic physicians in the county, four of whom have licenses to practice medicine; and there are eleven chiropractors.

Membership — Approximately 170 doctors practice in Monmouth County, of whom 137 have their names on the society's rolls. Four new members have been admitted this year, and the Membership Committee has surveyed the possibilities of those who are not members.

Scientific Program—Monthly meetings have been held,—excepting July and August,—at which scientific programs of excellent merit have been presented. On two occasions, members of the society have presented the papers; and at other times, guest speakers have been the rule. One meeting was devoted to medical economics.

Committees—The first aim of this year's program has been to strengthen the county society's organization. So far as the county's needs indicated, committees have been formed paralleling those of the State Society; and members and chairmen have been instructed to acquaint themselves with the State Society program and progress reports.

An additional committee, called the *Junior Executive Committee*, was also formed with the idea of appointing to it younger members who could be in training for positions of responsibility later on, and also have a voice through representation on the Executive Committee in presenting their problems to the sen-

ior committee. Their work has not been significant this year, but a beginning has been made, and in conjunction with similar appointments on other committees the young men of this society are getting an experience in planning and in leadership which should stand us in good stead in years to come.

Public Health and Relief—This society has a great degree of coördination with the County Board of Freeholders, the Monmouth County Organization for Social Service, and the Regional Health Commissions; and also with the hospitals. Monmouth County is unusually public health-minded, both in its lay and professional groups, and a spirit of friendly coöperation exists which makes it possible to handle problems affecting the indigent, state charges, jail population, and related groups. A county Venereal Disease Board, consisting of a representative of the Board of Freeholders, State Department of Health's Bureau of Venereal Disease Control, the Nursing Association, the Medical Society, and the County Public Health Officers, meets once a month regularly to discuss plans for enlarging and better administrating the county-wide clinics, and estimated appropriations for each coming year. This is a venture much to be recommended to other counties, since it smooths out misunderstandings which might otherwise arise, as well as steps up the interest and keenness of the representatives of the participating agencies.

The Monmouth County report in the State Medical Journal, February, 1939, issue, page 130, is a good example of how a society may coöperate with the welfare, nursing, and lay agencies in meeting puzzling situations. A tuberculosis survey of 100 cases in children, which will be carried out systematically

through a period of years is now in progress. The society has received from the infantile paralysis funds derived from the President's Birthday Ball, over \$800, to be used at its discretion if an epidemic arises, or special apparatus needs to be provided in any phase of its work. These are examples of the breadth of interest and activity of a moderate-sized society, operating in a largely rural county.

SUMMARY

The Monmouth County Medical Society is trying to do its share in following the program developed by the State Society. It participates intimately in the health problems of its county. Its membership is strong and well integrated. But probably, as in most other component societies, there is an increasing need for realization on the part of its members that they must each and every one keep more vitally abreast of changes in the field of the practice of medicine. Each member must develop a greater sense of responsibility to his society, and do an intelligent piece of work if he be on any committee. This requires training and a willingness to learn what is being done throughout the State and nation. There is not so much danger that the Monmouth County Medical Society will fail to advance both scientifically and administratively, as that many members will be puzzled by the speed of changing events, and uncertain as to what measures to employ to control them.

To President Carrington and the State officers, this society sends its greetings and congratulations, and voices its appreciation of the intelligent and stimulating leadership that they have given throughout the year 1938-1939.

REPORT OF THE MORRIS COUNTY MEDICAL SOCIETY

By THOMAS S. THOMAS, JR., M.D., President, Morristown, N. J.

To the House of Delegates:

The Morris County Medical Society has attempted several new trends of work during the past year.

While there are a number of non-members in the county, yet most of them are either inactive or retired, or are employed outside of the county. The paid-up membership of this year considerably exceeds that of other years.

Business meetings have been held each month; and at each one guest speakers have given addresses which have been reported in the county society reports in *The Journal*.

Representatives of our county society have attended the Welfare Committee meetings of the State Society and have promptly reported them to us.

The need and supply of medical care in Morris County has been fully investigated. The results of the survey indicate that the people of Morris County are receiving adequate medical care.

The Maternal Welfare Committee has been diligently following up its line of work.

Venereal Disease Control has received special attention. At first this project aroused

much discussion, and gave rise to differences of opinion regarding the establishment of clinics. However, after full discussion it was voted that the county should establish four clinics,—in Morristown, Dover, Boonton, and Madison. Three of these four clinics are now in operation.

The Cancer Control problem has aroused much interest among the physicians of Morris County. A tumor section has been organized in the Morristown Memorial Hospital. The county society has maintained the active direction of the cancer control problem within the county. The subject has been freely discussed in the society and in its Executive Committee, with the result that provision has been

made for both radium and high-voltage x-rays in the county.

Newspaper advertising has been attempted in our county. On October 15, 1938, the editors of fifteen newspapers were asked if they were willing to print a health feature—"The M.D. Says". Two editors replied that such a feature would be free publicity and that the feature should be placed among the paid advertisements. No reply was received from the thirteen other editors.

Pneumonia control has aroused increasing interest. The serum is available in two stations. Lectures have been delivered on the serum treatment.

REPORT OF THE OCEAN COUNTY MEDICAL SOCIETY

By EMANUEL M. SICKEL, M.D., President, Lakewood, N. J.

To the House of Delegates:

The following is a résumé of the activities of the Ocean County Medical Society during the year 1938-39:

COLLECTION SYSTEM

The year 1937-38 was concerned principally with the establishment of a collection and credit system for our members who were burdened with the problem of poor collections. This was set up under the direction of one man, approved by us, under the caption *Ocean County Medical Bureau*. During this past year, I would say that this system of collecting our outstanding accounts has not worked out satisfactorily, principally, I believe, because the men did not support it.

SCIENTIFIC WORK

We have had an excellent scientific year, considering that we have a small county membership, thereby making it an imposition to ask outstanding men to travel sixty miles to talk to only twelve or fifteen doctors. The members do not seem to realize the need for a good showing at these meetings. The speakers whom I have been able to get were enjoyed by those attending, as evidenced by spirited discussions.

PROSECUTOR'S OFFICE

Other activities this year were mostly in the form of a "*Prosecutor's Office*". We had to

counteract inroads into the medical practice which were being made by some of the cults. One of the biggest of these problems, interfering with the practice of medicine, was one man, operating a so-called *inhalatorium* without medical supervision, and resorting to unethical advertising and publicity. We have adequately handled this situation.

Another matter injurious to the physicians' practice in the surrounding communities still exists at the U. S. Naval Air Station where, it is alleged, the physicians in the employ of the government, and on full pay, practice competitively, using all the available government medical resources, without cost to the patient.

PERSONAL SERVICE

One constructive criticism is the necessity for every member to realize that a county society depends entirely on the interest and presence of its members at every meeting. It is true that the main activities are the duties of its officers; yet the interest of the other members is most encouraging to the officers, and goes to make up a successful and profitable year. Every man must be content to sacrifice a little of his time to attend committee meetings so that his first-hand reports will keep the county-State Society relationship actively alive.

REPORT OF THE PASSAIC COUNTY MEDICAL SOCIETY

By LOUIS G. SHAPIRO, M.D., President, Paterson, N. J.

To the House of Delegates:

There has been no outstanding innovation in the component Medical Society of Passaic County during the past year. We have proceeded to perfect our organization.

EXECUTIVE OFFICE

The Executive Office is now in its second year, and is proving valuable in caring for a steadily mounting mass of correspondence and detail. It is well located in the County Court House Annex, and is efficiently administered by our Executive Secretary, Miss Elsie Wildanger, under the guidance of our Secretary, Dr. J. Allen Yager.

WELFARE COUNCIL

The officers constitute a Welfare Council, which meets monthly several days prior to the regular meeting of the society. Here the society's policies are discussed, and much routine business is cared for, avoiding its presentation to the society as a whole.

A monthly bulletin informs the membership of business transacted by the Welfare Council, and contains all committee reports.

PROGRAMS OF MEETINGS

During the current year, the majority of the medical meetings were arranged by the various committees. This departure in arrangement of the program has added interest to the meetings. In recent years, our regular stated meetings have been devoid of all clinical presentations by our own membership. This, in a large measure, is regrettable. In an attempt to compensate for this lack, and to familiarize the members with the work done in the various hospitals and by the men in the various hospital

groups, clinical meetings were held in the hospitals under the auspices of the county medical society. Attendance at these meetings was uneven, the addition of a second monthly meeting being a disadvantage. It remains to be seen whether or not these clinical meetings will be continued in the ensuing year.

RELIEF FUND

During the current year a relief fund for physicians in need was organized by assigning one dollar of each member's annual dues to this fund. It is hoped that after several years the money in hand will be sufficiently large to meet any need that may arise.

COMMITTEES

The several committees have made progress in their allotted tasks. The *Cancer Committee* has been instrumental in organizing an active County Committee for the Control of Cancer that is affiliated with the National Society. This committee is active and is steadily building up its organization.

The Committee on *Mental Hygiene* is devoting its efforts to securing proper hospital accommodations within the county for the mentally ill. The problem of the *medical care of the indigent* is being discussed in committee and in the Council. At this moment, no plans for the county have been developed.

Our profession has become a more closely knit organization during the past several years. It is the hope of the officers that a steadily increasing proportion of the membership will become interested in the work of the county and state societies. Such increased interest is necessary to meet the many problems that confront the profession today.

REPORT OF THE UNION COUNTY MEDICAL SOCIETY

By HENRI E. ABEL, M.D., President, Elizabeth, N. J.

To the House of Delegates:

During the past year a full-time Executive Secretary was engaged by the county society. For this position Dr. Katherine Falconer, a graduate of Cornell Medical School in 1933, has brought the medical point of view so necessary in these times of economic stress. Her duties not only include the regular routine secretarial work incident to the functioning of a group of 350 physicians, but also the management of the Medical Service Bureau, which handles installment payments of doctors' bills and the collection of old bills. The Secretary will act as contact physician with the public, representing the profession as speaker before lay groups, acting as the medical representative in legislative matters, and doing general publicity work. The society feels that it will now for the first time have some one who can devote full time to the advancement of the medical fraternity in this county, and do it in an efficient manner.

CANCER CLINIC

The Elizabeth General Hospital has established a well-equipped Cancer Clinic to take care of county cases. For some time all cancer cases requiring radiation have been sent out of town because of the lack of suitable facilities. Now with a full-time expert, a graduate of Memorial Hospital in New York City, in charge, and an adequate deep x-ray and radium supply on hand, no case needs to go out of the county.

TRAINING PRACTICAL NURSES

The Elizabeth Vocational School has just finished the first year of a course designed to train girls in practical nursing. This was the second course established in New Jersey, the first having been started in Newark last year. The county society was instrumental in starting, as well as supervising, this very necessary course, which will insure a supply of trained personnel for homes where a regular trained nurse is either not necessary or too expensive for the family.

REFERENCE COMMITTEES

The annual reports of the officers and committees will be referred to reference committees for study, and for recommendations to the House of Delegates.

Abundant opportunity will be given to any member of the State Society to express his opinions or wishes regarding any report, in two ways:

1. He may communicate with the chairman of the proper reference committee.

2. He may express his views directly to the reference committee, each of whom will hold hearings during the annual meeting. Notices of the times and places of these hearings will be posted in conspicuous places during the annual meeting.

The following is a list of the Reference Committees appointed by President Carrington in accordance with the By-Laws, Chapter VIII, Sections 12 and 13.

Reference Committee "OFF" to consider reports of:

The President
The Board of Trustees
The Executive Officer
The Secretary

Addresses of the President and President-Elect

Walter J. Farr, Chairman	Bergen County
Reeve L. Ballinger	Hudson
Henry B. Orton	Essex
Adolph Towbin	Ocean
J. Allen Yager	Passaic

Reference Committee "PUB" to consider reports of:

The Publication Committee
The Sub-Committee on Public Relations
County Society Presidents

James F. Norton, Chairman	Hudson County
Marcus H. Greifinger	Essex
D. Leo Haggerty	Mercer
Arcangelo Liva	Bergen
Bernard C. McMahon	Morris

Reference Committee "FIN" to consider reports of:

The Committee on Finance and Budget
The Treasurer

Edward W. Sprague, Chairman...Essex County
Henri E. AbelUnion
Samuel A. CosgroveHudson
Andrew F. McBridePassaic
Saul M. RubinowEssex

Reference Committee "LAW" to consider reports of:

The Sub-Committee on Legislation
The Judicial Councilors

David B. Allman, Chairman...Atlantic County
William H. AresonEssex
G. Barton BarlowBergen
George F. DandoisCape May
Earl C. LyonCumberland

Reference Committee "PROG" to consider reports of:

The Committee on Program and Arrangements
The Sub-Committee on Scientific Program
The Sub-Committee on Scientific Exhibits
The Advisory Committee to the Woman's Auxiliary

Joseph F. Londrigan, Chairman...Hudson Co.
William H. LongSomerset
Louis G. ShapiroPassaic
John V. SmithMiddlesex
H. Burton WalkerCumberland

Reference Committee "WEL" to consider the report of:

The Welfare Committee

Clarence W. Way, Chairman...Cape May County
A. Dunbar HutchinsonMercer
Carlos PonsMonmouth
E. LeRoy WoodEssex
George J. YoungMorris

Reference Committee "PGEX" to consider reports of:

The Sub-Committee on Public Health
The Advisory Committee on Cancer Control
The Advisory Committee on Venereal Disease Control
The Advisory Committee on Mental Hygiene
The Advisory Committee on Adult Health Supervision
The Advisory Committee on Tuberculosis
The Advisory Committee on Child Health
The Advisory Committee on Maternal Welfare
The Advisory Committee on Crippled Children
The Advisory Committee on Pneumonia Control
The Advisory Committee on Traffic Accidents

David W. Green, ChairmanSalem County
Frank W. AshPassaic
Jesse McCallSussex
H. Roy Van NessEssex
William C. WilentzMiddlesex

Reference Committee "MP" to consider reports of:

The Sub-Committee on Medical Practice
The Advisory Committee on Contract Practice
The Advisory Committee on Hospital Relationships
The Advisory Committee on Medical Care of the Indigent
The Advisory Committee on Nursing and Nursing Education
The Advisory Committee on Pharmaceutical Problems
The Advisory Committee on Workmen's Compensation
The Advisory Committee on Auxiliary Medical Services
The Advisory Committee on Industrial Injuries and Occupational Diseases

Earl H. Snavelly, ChairmanEssex County
Austin H. ColemanHunterdon
Daniel F. FeatherstonMonmouth
Henry HaywoodMiddlesex
Charles H. deT. ShiversAtlantic

Reference Committee "INS" to consider reports of:

The Committee on Medical Defense and Insurance
The Committee on Voluntary Health Insurance

Hilton S. Read, Chairman.....Atlantic County
Vincent P. ButlerHudson
Harry N. ComandoEssex
Donald O. HamblinSomerset
Fred VosburghPassaic

Reference Committee "MISC" to consider:

Miscellaneous Business

Elmer P. Weigel, ChairmanUnion County
Frank BienEssex
J. Lawrence EvansHudson
D. Ward ScanlanAtlantic
S. Emlen StokesBurlington

SPECIAL REFERENCE COMMITTEES**I. Credentials**

Thomas B. Lee, Chairman...Camden County
Elias J. Marsh, ex-officioPassaic
Alfred Stahl, ex-officioEssex

II. Resolutions and Memorials

Max Danzis, ChairmanEssex County
Ellis J. ChapmanHudson
Emlen P. DarlingtonBurlington
Wayne W. HallPassaic
Ernest G. HummelCamden

III. Constitution and By-Laws

Samuel Alexander, Chairman...Bergen Co.
Thomas McG. BrennockHudson
Eugene G. HerbenerOcean
Edward C. Klein, Jr.Essex
Robert A. MacKenzieMonmouth

REPORT OF STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

By E. S. HALLINGER, M.D., F.A.C.S., Secretary

During the period of March 15th, 1938, to March 23rd, 1939, the Board examined 339 applicants for a license to practice medicine and surgery. Fifty-eight of these applicants were licensed osteopaths who qualified for the examination by submitting evidence of having completed an acceptable post-graduate course of two years in an approved college, or an acceptable internship of two years in an approved hospital, in accordance with the provisions of Section 45:9-14.1 of the Revised

The Board also examined seventy-six applicants for a license to practice osteopathy; three applicants for a license to practice chiropractic; and six applicants for a license to practice chiropody.

One hundred and sixty-two licenses were issued to applicants for endorsement of a license from another state, who presented credentials to prove they could meet the requirements for examination that were in force in New Jersey at the time they were examined.

TABLE I—SHOWING NUMBER OF CANDIDATES FOR THE 1938 EXAMINATIONS,
CLASSIFIED AS GRADUATES OF MEDICAL COLLEGES IN THE UNITED
STATES AND FOREIGN COUNTRIES AND ACCORDING
TO CITIZENSHIP

	Citizens	*Non-Citizens	Total	Passed	Percentage Failed
MEDICAL					
<i>United States</i>					
Graduates of Medical Schools	163		163	162	.006
Licensed Osteopaths who qualified for a Full License to Practice Medicine and Surgery	59		59	46	22.
Canada	4	2	6	6	
Great Britain	2	1	3	3	
France		1	1		100.
Germany	2	55	57	33	42.1
Italy	26	6	32	16	50.
Switzerland	1	1	2	2	
Austria	6	8	14	11	21.4
Czechoslovakia		1	1	1	
Hungary		1	1	1	
OSTEOPATHIC					
United States	76		76	67	10.8
CHIROPRACTIC					
United States	3		3	3	
CHIROPODY					
United States	6		6	4	33.3
	348	76	424	355	16.2

* Each of those who were not citizens submitted a *declaration of intention* to become a citizen, and was granted a license valid for six years from the date of declaration.

Statutes of New Jersey. Four of the applicants were graduates of non recognized medical schools that were admitted under the provisions of Chapter 154, Laws of 1938, which did not give the Board power to determine the standing of the colleges from which the applicants graduated. This law ceased to exist on January 1st, 1939. One of the applicants who had completed a four years' course of study in a recognized medical college, but had not received a diploma, was admitted under the provisions of Chapter 121, Laws of 1938, which requires the Board to admit an applicant who can meet the special requirements contained in the law.

TABLE II—SHOWING LICENTIATES BY ENDORSEMENT
CLASSIFIED AS GRADUATES OF COLLEGES IN THE UNITED
STATES AND FOREIGN COUNTRIES, AND ACCORDING TO
CITIZENSHIP

Countries	Total	Citizens	*Non-Citizens
United States	141	140	1
Great Britain	2	2	
Germany	4		4
Italy	1		1
Austria	2	1	1
Canada	7		7
Switzerland	5		5
	162	143	19

* Those who were not citizens submitted a *declaration of intention* to become a citizen, and were granted a license valid for six years from date of declaration.

All credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals before a license was issued; also licenses issued to applicants in foreign countries that were submitted by candidates for the examination who were graduates of foreign medical schools, and licenses issued in the United States submitted by applicants for endorsement.

The laws governing the practice of medicine and surgery, osteopathy, and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of such licentiates practicing in the State is increasing or decreasing.

Physicians—Endorsed to Other States.....	81
Osteopaths—Endorsed to Other States.....	21
Medical License Revoked	1
Midwifery Licenses Revoked	2
Deceased Physicians	99
Deceased Osteopaths	2
Deceased Chiropractors	2
Deceased Chiropodists	1
—	209

TABLE III—SHOWING NUMBER OF PHYSICIANS AND SURGEONS, AND OSTEOPATHS, ENDORSED TO OTHER STATES, THE NUMBER OF LICENTIATES OF WHOSE DEATH THE BOARD RECEIVED A RECORD, AND THE NUMBER OF LICENSES REVOKED.

This table covers the physicians who died in New York City, but does not include those who died in other parts of New York State, nor in other states of the United States; nor does it include the number of physicians who are licensed in other states as well as New Jersey that leave New Jersey to practice in some other state in which they are licensed.

An annual registration would give the Board accurate information in regard to the number of physicians practicing in New Jersey, and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed physicians in their vicinity. If either of the Bills before the Legislature requiring citizenship is enacted, there will undoubtedly be an increase in the number of regular physicians practicing without a license.

The laws governing the practice of chiropody and midwifery do provide for an annual registration, and our records show a decrease of two in the number of chiropodists that registered on November 1st, 1938, and a decrease of twenty-five midwives for the same period.

ENFORCEMENT

The license of one physician and surgeon was revoked for conviction of a crime involv-

ing moral turpitude; one was suspended for conviction of a violation of the Harrison Narcotic Act; and two licenses became invalid and were automatically revoked through failure of the licensees to present evidence of citizenship. Complaint against one physician and surgeon was dismissed. Petition for reinstatement of one license was refused, and another was granted. The licenses of two midwives were revoked, one for conviction of the practice of criminal abortion, and one on testimony produced before the Board for the practice of criminal abortion.

TABLE IV—SUMMARY OF BOARD'S ACTIVITIES IN ENFORCING THE LAWS THEY ADMINISTER

<i>Court Cases—Violation of Medical, Etc., Laws</i>	
Convicted, Pleased Guilty or Settled.....	24
Lost, No Appeal	2
Decision Reserved	1
Pending in the Courts	17
—	44
<i>Cases—Supreme Court</i>	
Writ of Certiorari Allowed in Case Won by Board, Abandoned by Defendant	1
<i>Hearings Before Board</i>	
Medical—License Revoked	1
Medical—License Suspended	1
Medical—Complaint Dismissed	1
Medical—Licenses Invalid Through Failure to Present Evidence of Citizenship.....	2
Medical—Petition for Reinstatement Refused	1
Medical—Petition for Reinstatement Granted ..	1
Midwifery—Licenses Revoked	2
—	9
—	54

	No. Investigated	No. Visits
<i>Type of Cases Investigated</i>		
Druggists Practicing Medicine..	51	371
Prescribing Herbs, Drugs and Appliances	24	114
Medical Doctors	14	80
Unlicensed Chiropractors	21	164
Chiropractors Exceeding License	9	85
Osteopaths, Licensed and Exceeding License	3	34
Chiropodists, Unlicensed and Exceeding License	10	63
Electro-therapists	7	55
Laying-on-of-Hands	2	2
Masseurs and Massage Treatments	4	36
Naturopaths	16	93
Midwives, Unlicensed, Not Registered and Exceeding License ..	2	4
Miscellaneous	48	83
Medical Revocation	3	12
Midwifery Revocation	2	20
Colonic Therapists	1	6
—	217	1,222

Average Number of Visits per Investigators.... 5.6

THE 173rd ANNUAL MEETING of the The Medical Society of New Jersey SCHEDULE OF EVENTS HADDON HALL, ATLANTIC CITY, N. J.

Monday, June 5, 1939

REGISTRATION

12:00 noon—Registration opens

All officers, delegates, members of component County Societies, guests, and exhibitors are requested to register at the Registration Desk in the Exhibit Hall on the Lounge Floor immediately upon arrival.

5:00 p.m.—Inspection of Exhibits

Scientific—Vernon Room, Lounge Floor

Technical—Parlor, Lounge Floor

Art, Hobby, and Medical History—Sun Porch, Lounge Floor

8:00 p.m.—Board of Trustees Meeting
Mandarin Room, 13th Floor

8:30 p.m.—Judicial Council Meeting
Green Room, 13th Floor

Tuesday, June 6, 1939

9:30 a.m.—Combined Sections on Eye, Ear, Nose and Throat and Radiology
Rutland Room, First Floor

9:30 a.m.—Combined Sections on Obstetrics and Gynecology and Pediatrics
Viking Room, 13th Floor

11:00 a.m.—Combined Sections on Gastro-Enterology and Surgery
Garden Room, Lounge Floor

2:30 p.m.—House of Delegates
Garden Room, Lounge Floor

5:00 p.m.—Inspection of Exhibits

8:30 p.m.—General Public Session
Viking Room, 13th Floor

9:30 p.m.—Nominating Committee Meeting
Mandarin Room, 13th Floor

Wednesday, June 7, 1939

9:00 a.m.—Section on Radiology
Derbyshire Room, First Floor

9:00 a.m.—First Section on Medicine
Rutland Room, First Floor

9:30 a.m.—Section on Pediatrics
Viking Room, 13th Floor

10:00 a.m.—Section on Surgery
Garden Room, Lounge Floor

12:30 p.m.—House of Delegates
Garden Room, Lounge Floor

1:00 p.m.—Woman's Auxiliary Luncheon
Benjamin West Room, 13th Floor

1:00 p.m.—Joint Committee on Professional Relations Luncheon
Room 137, First Floor

1:15 p.m.—Luncheon to George Muller, M.D., F.A.C.S., President-Elect, American College of Surgeons.

2:30 p.m.—House of Delegates
Garden Room, Lounge Floor

5:00 p.m.—Inspection of Exhibits

7:30 p.m.—Reception to President

8:00 p.m.—Dinner Dance in honor of President and Mrs. Carrington

Thursday, June 8, 1939

9:00 a.m.—Section on Medicine
Rutland Room, First Floor

9:30 a.m.—Section on Eye, Ear, Nose and Throat Surgery
Derbyshire Room, First Floor

9:30 a.m.—Section on Gastro-Enterology
Garden Room, Lounge Floor

9:30 a.m.—Section on Obstetrics and Gynecology
Viking Room, 13th Floor

1:30 p.m.—House of Delegates
Garden Room, Lounge Floor

3:30 p.m.—Joint Meeting with the New Jersey Hospital Association
Viking Room, 13th Floor

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY TWELFTH ANNUAL MEETING Haddon Hall, Atlantic City

TUESDAY, JUNE 6, 1939

10:00 a.m.—Registration
Exhibit Hall, Lounge Floor

2:30 p.m.—Executive Board Meeting
Solarium, Lounge Floor

8:30 p.m.—General Public Session
Viking Room, 13th Floor

WEDNESDAY, JUNE 7, 1939

9:30 a.m.—Business Session
Solarium, Lounge Floor

12:30 p.m.—Memorial Services for Departed Members
Solarium, Lounge Floor

1:00 p.m.—Auxiliary Luncheon (Fee \$2.00)

Benjamin West Room, 13th Floor

2:30 p.m.—Business Session
Solarium, Lounge Floor

3:30 p.m.—"Medical History in New Jersey"—Dr. Frank Overton

Art, Hobby, and Medical History Exhibit
Sun Porch, Lounge Floor

4:00 p.m.—Art and Hobby Tea
Sun Porch, Lounge Floor

7:30 p.m.—President's Reception

8:00 p.m.—President's Dinner-Dance

THURSDAY, JUNE 8, 1939

10:00 a.m.—New Executive Board Meeting
Solarium, Lounge Floor

GENERAL PUBLIC SESSION**Tuesday Evening, June 6, 1939, 8:30 P. M.**

Viking Room, 13th Floor

1. Governmental Planning for Health—Haven Emerson, M.D., New York City
2. Medical Problems of the Day—Rock Sleyster, M.D., Wauwatosa, Wisconsin
3. The Doctor at the Crossroads—Nathan B. Van Etten, M.D., New York City

COMBINED SCIENTIFIC SECTIONS**1. SECTIONS ON EYE, EAR, NOSE,
AND THROAT****and****RADIOLOGY****Tuesday Morning, June 6, 1939**

Rutland Room, First Floor

Dr. Charles F. Baker presiding, by invitation

9:30 A. M.

1. Diagnosis of Mastoiditis, Roentgenologically Considered
N. J. Furst, M.D., Newark

10:00 A. M.

2. Diagnosis of Mastoiditis, Otologically Considered
Richard D. Swain, M.D., Newark

10:30 A. M.

3. X-Ray Localization of Intraocular Foreign Bodies from the Viewpoint of the Ophthalmologist
A. Russell Sherman, M.D., Newark

11:00 A. M.

4. Treatment of Tumors of Paranasal Sinuses, Radiologically Considered
Milton Friedman, M.D., Newark

11:30 A. M.

5. Neoplasms of the Naso-Pharynx and the Paranasal Sinuses
William Law Watson, M.D., New York City

**2. SECTIONS ON OBSTETRICS AND
GYNECOLOGY
and
PEDIATRICS****Tuesday Morning, June 6, 1939**

Viking Room, 13th Floor

10:00 A. M.

1. Infant Resuscitation
Arthur Heyman, M.D., Senior Pediatrician,
Beth Israel Hospital, Newark
Speaker provided by the Officers of the Section on Pediatrics

10:30 A. M.

2. Fetal Respiration and Its Relation to Asphyxia, Atelectasis, and Pneumonia of the Newborn
Franklin F. Snyder, M.D., Assistant Professor of Obstetrics and Gynecology, School of Medicine of Division of Biological Sciences, University of Chicago, Chicago, Ill.
Discussion opened by Dr. Edward W. Ripley, Montclair, Attending Pediatrician, Mountainside Hospital, Montclair, and Essex County Isolation Hospital, Belleville.

11:00 A. M.

3. Birth Fractures and Epiphyseal Dislocations
Edward D. Truesdell, M.D., Attending Surgeon, Lincoln Hospital; Associate Surgeon, St. Luke's Hospital, New York City
Discussion opened by Dr. G. Herbert Taylor, East Orange, Attending Orthopedist, Orange Memorial Hospital, Orange; and East Orange General Hospital, East Orange.

11:30 A. M.

4. Cyanosis of the Newborn
Ralph Tyson, M.D., Philadelphia, Pa.
Speaker provided by the Officers of the Section on Pediatrics

3. SECTIONS ON GASTRO-ENTEROLOGY and SURGERY**Tuesday Morning, June 6, 1939**

Garden Room, Lounge Floor

11:00 A. M.

1. The Medical Approach to the Gall-Bladder Problem
S. B. Kaplan, M.D., Beth Israel Hospital, Newark

11:20 A. M.

2. The Preparation of the Patient for Gall-Bladder Surgery with Especial Reference to Jaundice
I. Ravdin, M.D., University of Pennsylvania, Philadelphia, Pa.

11:40 A. M.

3. The Selection of Cases of Peptic Ulcer for Surgery
Hilton S. Read, M.D., Atlantic City

12:00 Noon

4. Radical Versus Conservative Surgical Procedures for Peptic Ulcer
Alfred Strauss, M.D., Michael Reese Hospital, Chicago, Ill.

SCIENTIFIC SECTIONS

1. MEDICINE

JOHN W. GRAY, *Chairman*
A. RUSSELL SHERMAN, *Secretary*

FIRST SESSION

Wednesday Morning, June 7, 1939

Rutland Room, First Floor

Each paper will be followed by a ten-minute general discussion

9:00 A.M.

1. Common Colds
Yale Kneeland, Jr., M.D., Associate Professor of Medicine, College of Physicians and Surgeons, Columbia University, New York City

9:30 A.M.

2. Paranasal Sinusitis from the Internist's Point of View
George H. Lathrope, M.D., Newark

9:55 A.M.

3. Influenza and Its Sequelae in the Cardiovascular System
Clarence L. Andrews, M.D., Atlantic City

10:20 A.M.

4. Differentiation of Tuberculous and Non-Tuberculous Pulmonary Infections
Abraham E. Jaffin, M.D., Jersey City

10:45 A.M.

5. Is Respiratory Infection an Etiologic Factor in Bronchial Asthma?
Harry L. Rogers, M.D., Riverton

11:10 A.M.

6. Recent Advances in the Study of Pneumonia
Robert A. Kilduffe, M.D., Atlantic City
Discussion opened by Harvey M. Ewing, M.D., Montclair.

11:35 A.M.

7. "Colds", Climate and Rheumatic Fever
Hobart A. Reimann, M.D., Professor of Medicine, Jefferson Medical School, Philadelphia

SECOND SESSION

Thursday Morning, June 8, 1939

Rutland Room, First Floor

Each paper will be followed by a ten-minute general discussion

9:00 A.M.

1. Vasomotor Regulation of the Temperature of the Extremities in Health and Disease
Bayard T. Horton, M.D., Assistant Professor of Medicine, Mayo Clinic, Rochester, Minn.

9:30 A.M.

2. Hyperchromic Anemia
Samuel J. Penchansky, M.D., Bayonne

9:55 A.M.

3. Cord Lesions in Pernicious Anemia
Ambrose F. Dowd, M.D., Newark

10:20 A.M.

4. Indications for Estrogenic Therapy
Thomas B. Lee, M.D., Camden
Discussion opened by Franklin L. Payne, M.D., Philadelphia, Pa.

10:45 A.M.

5. Cardiac Pain
Frederic A. Alling, M.D., Newark

11:10 A.M.

6. Toxic Hepatitis Following Drug Therapy
Harrison S. Martland, M.D., Essex County Medical Examiner, Newark

11:40 A.M.

7. The Modern Concept of Renal Pathology and Morbid Physiology
Frank W. Konzelmann, M.D., Professor of Clinical Pathology, Temple University, Philadelphia, Pa.

12:10 P.M.

Election of Officers

2. SURGERY

ROBERT S. GAMON, *Chairman*
LYNDON A. PEER, *Secretary*

Wednesday Morning, June 7, 1939

Garden Room, Lounge Floor

10:00 A.M.

1. Prostatic Hypertrophy—A New Method of Grouping Cases for Operation
Charles deT. Shivers, M.D., Atlantic City

10:30 A.M.

2. The Management of Acute Head Injuries
Richard D. Swain, M.D., Newark

11:00 A.M.

3. Surgery of the Colon and Rectum
B. B. Ranson, M.D., East Orange

11:30 A.M.

4. Osteomyelitis
John E. Toye, M.D., Arlington

12:00 Noon

5. The Acute Appendicitis Problem from the Surgical Standpoint
George P. Muller, M.D., Professor of Surgery, Jefferson Medical College; President-Elect, American College of Surgeons, Philadelphia, Pa.

12:30 P.M.

Election of Officers

3. EYE, EAR, NOSE, AND THROAT

NORMAN W. BURRITT, *Chairman*
A. RUSSELL SHERMAN, *Secretary*

Thursday Morning, June 8, 1939

Derbyshire Room, First Floor

9:30 A. M.

1. Sight Conservation
Elias J. Marsh, M.D., Paterson

10:00 A. M.

2. Differential Diagnosis of Fundus Lesions Associated with Hypertensive Vascular Disease
Martin Cohen, M.D., New York City

10:30 A. M.

3. Operation for the Relief of Otosclerosis
Julius Lempert, M.D., New York City

11:00 A. M.

4. Advances in Technique of Radical Mastoid Surgery
Edgar P. Cardwell, M.D., Newark

11:30 A. M.

Election of Officers

4. GASTRO-ENTEROLOGY

MANFRED KRAEMER, *Chairman*
HYMAN I. GOLDSTEIN, *Secretary*

Thursday Morning, June 8, 1939

Garden Room, Lounge Floor

9:30 A. M.

1. Experiences in Diagnosis with the Peritoneoscope: Indications for Its Use
C. Abbott Beling, M.D., Hospital of St. Barnabas and for Women and Children, Newark

9:50 A. M.

2. The Treatment of Intestinal Obstruction with the Double-Barreled Intestinal Tube
W. Osler Abbott, M.D., University of Pennsylvania, Philadelphia

10:30 A. M.

3. Vascular Diseases of the Digestive Tract
Stuart Z. Hawkes, M.D., Presbyterian Hospital, Newark

11:00 A. M.

4. Functional Disorders of the Colon
Sigurd Johnsen, M.D., Passaic General Hospital, Passaic

11:30 A. M.

5. The Constitutionally Inadequate Patient
Walter Alvarez, M.D., Mayo Clinic, Rochester, Minn.

12:00 Noon

Election of Officers

5. OBSTETRICS AND GYNECOLOGY

WALTER B. MOUNT, *Chairman*
J. CARLISLE BROWN, *Secretary*

Thursday Morning, June 8, 1939

Viking Room, 13th Floor

10:00 A. M.

1. Perineal Repair; Choice of Operation
David N. Barrows, M.D., Adjunct Professor of Gynecology and Obstetrics, Polyclinic Medical School and Hospital; Lecturer in Gynecology and Obstetrics, New York University College of Medicine, New York City

Discussion opened by Carl H. Ill, M.D., Newark, Attending Obstetrician, Hospital of St. Barnabas, and for Women and Children.

10:30 A. M.

2. Cystocele
Joshua W. Davies, M.D., Instructor in Anatomy, Columbia University, College of Physicians and Surgeons; Assistant Obstetrician, Knickerbocker Hospital; Junior Surgeon, Woman's Hospital, New York City

Discussion opened by Meredith F. Campbell, M.D., Montclair, Professor of Urology, New York College of Medicine; and Associate Visiting Urologist, Bellevue Hospital.

11:00 A. M.

3. Hormonal Treatment of Senile Vulvo-Vaginitis; Report of Fifty Cases
Rita S. Finkler, M.D., and Zelda I. Marks, M.D., Newark, Attending Gynecologist and Assistant Gynecologist, Newark Beth Israel Hospital
Discussion opened by John Huberman, M.D., Newark, Attending Gynecologist, Newark Beth Israel Hospital.

11:30 A. M.

4. Uterine Hemorrhage and Its Management
Edward A. Schumann, M.D., Professor of Obstetrics, University of Pennsylvania School of Medicine, Philadelphia, Pa.
Discussion opened by Robert A. MacKenzie, M.D., Asbury Park, Attending Obstetrician, Monmouth Memorial Hospital, Long Branch; and Raleigh Fitkin-Paul Morgan Memorial Hospital, Neptune.

12:00 Noon

5. Extra-peritoneal Cesarean Section (colored movie)

Edward G. Waters, M.D., Assistant Professor of Clinical Obstetrics and Gynecology, Columbia University, College of Physicians and Surgeons, New York City; Division Chief of Obstetrics, Margaret Hague Memorial Hospital, Jersey City

Discussion by Samuel A. Cosgrove, M.D., Jersey City, Clinical Professor of Obstetrics, Columbia University; Medical Director and Attending Obstetrician, Margaret Hague Maternity Hospital.

12:30 P. M.

Election of Officers

6. PEDIATRICS

IRVING OKIN, *Chairman*
WARREN RIPLEY, *Secretary*

Wednesday Morning, June 7, 1939

Viking Room, 13th Floor

9:30 A. M.

1. The Essex County Child Welfare Plan
Chester Brown, M.D., Newark

10:00 A. M.

2. The Treatment of Rheumatic Heart Diseases in Children
L. Charles Rosenberg, M.D., Newark

10:30 A. M.

3. The Evaluation of the Sedimentation Test as a Criterion of Activity in Ambulant Children Having a Positive Tuberculin Test
E. Harrison Nickman, M.D., Atlantic City

11:00 A. M.

4. The Diagnosis and Management of the Common Rectal Disorders in Infants and Children
C. D. Smith, M.D., Paterson

11:30 A. M.

5. The Pediatrician's Responsibility for the Supervision of Behavior in Children
Bronson Crothers, M.D., Boston, Mass.

12:00 Noon

6. Malignancies in Infancy and Childhood
A. G. DeSanctis, M.D., New York City

12:30 P. M.

Election of Officers

7. RADIOLOGY

MILTON FRIEDMAN, *Chairman*
W. JAMES MARQUIS, *Secretary*
Wednesday Morning, June 7, 1939

Derbyshire Room, First Floor

9:00 A. M.

1. Differential Diagnosis Between Intrathoracic Tumors and Inflammatory Processes
Henry K. Taylor, M.D., New York City

9:30 A. M.

2. Pathological Physiology of Diseases of the Lung
George Ornstein, M.D., New York City
Symposium on the Treatment of Inflammatory Processes by Radiation Therapy

10:00 A. M.

3. The Histology of Radiation Effects on Inflammatory Processes
Ralph Pomeranz, M.D., Newark

10:30 A. M.

4. The Roentgen Ray Treatment of Subdeltoid Bursitis
William G. Herrman, M.D., Asbury Park

11:00 A. M.

5. The Roentgen Ray Treatment of Sinusitis in Children
William J. Marquis, M.D., Newark

11:30 A. M.

6. The Roentgen Ray Treatment of Gas Bacillus Infection
Joseph Wyatt, M.D., Newark

12:00 Noon

7. The Roentgen Ray Treatment of Carbuncles
Ernest May, M.D., East Orange

12:30 P. M.

Election of Officers

GUEST SPEAKERS



WALTER C. ALVAREZ,
M.D., D.Sc.

Rochester, Minnesota

Professor of Medicine, University of Minnesota (Mayo Foundation); Past President, American Gastro-Enterological Association; Editor, American Journal of Digestive Diseases, and author of books on the subject.

P. 334



HAVEN EMERSON, M.D.

New York

College of Physicians and Surgeons, Columbia University, 1899

Professor of Public Health Practice, Columbia University Medical College. One-time Commissioner of Health of Greater New York City.

P. 332



DAVID NYE BARROWS,
M.D., F.A.C.S.

New York

Cornell Medical School 1912 Associate Gynecologist and Obstetrician, Bellevue Hospital; Lecturer in Gynecology, New York University Medical College.

P. 334



BAYARD T. HORTON,
M.D., F.A.C.P.

Rochester, Minnesota

University of Virginia 1922

Associate Professor of Medicine, the Mayo Foundation; Consultant in Medicine, the Mayo Clinic.

Author of publications on "Vascular Diseases".

P. 333



MARTIN COHEN, M.D.

New York

College of Physicians and Surgeons, Columbia University, 1898

Professor, Clinical Ophthalmology, New York Post-Graduate Medical School and Hospital; Consultant Surgeon, Manhattan Eye, Ear and Throat Hospital; Consultant Ophthalmologist, Harlem Hospital.

P. 334



F. W. KONZELMANN, M.D.

Philadelphia

Jefferson Medical College 1919

Professor, Clinical Pathology, Temple University Medical School. Pathologist to the Temple University Hospital.

Is showing pathological specimens in the scientific section of the Scientific Exhibit of The Medical Society of New Jersey.

P. 333



BRONSON CROTHERS, M.D.

Boston

Harvard Medical College 1910

Assistant Professor of Pediatrics, Harvard Medical College; Visiting Physician to the Children's Hospital, and to the Infants' Hospital, Boston.

P. 335



JULIUS LEMPERT, M.D.

New York

Long Island College of Medicine 1913

Surgical Director, Lempert Clinic, New York City.

P. 334



ADOLPH G. DeSANCTIS, M.D.

New York

Long Island College of Medicine 1901

Professor and Director of Pediatrics of the New York Post-Graduate Medical School and Hospital of Columbia University.

P. 335



GEORGE P. MULLER, M.D.

Philadelphia

University of Pennsylvania 1899

Professor of Surgery in the Jefferson Medical College; President-Elect American College of Surgeons.

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ANNUAL MEETING, June 6-8, 1939



GEORGE G. ORNSTEIN, M.D., F.A.C.P.

New York

New York University 1915

Director, Tuberculosis, Sea View Hospital; Associate Clinical Professor of Medicine, New York Medical College; Associate Clinical Professor, New York Post-Graduate Medical School of Columbia University.

P. 335



ALFRED A. STRAUSS, M.D.

Chicago

Rush Medical College 1908

Attending Surgeon, Michael Reese Hospital, and at Mount Sinai Hospital.

P. 332



I. S. RAVDIN, M.D.

Philadelphia

University of Pennsylvania 1918

Harrison Professor of Surgery; Director, Harrison Department of Surgical Research, University of Pennsylvania; Surgeon, Hospital of the University of Pennsylvania.

P. 332



HENRY K. TAYLOR, M.D.

New York

New York University Medical College 1915

Director Radiology, Sea View Hospital; Associate Director Radiology, Beth Israel Hospital; Instructor in Radiology, Columbia University.

P. 335



EDWARD A. SCHUMANN, M.D., F.A.C.S.

Philadelphia

University of Pennsylvania 1901

Gynecologist and Obstetrician, Philadelphia General Hospital. Formerly Professor of Obstetrics, University of Pennsylvania.

P. 335



EDWARD D. TRUESDELL, M.D.

New York

College of Physicians and Surgeons, Columbia University, 1906

Attending Surgeon, Lincoln Hospital; Associate Surgeon, St. Luke's Hospital. Author of a book on "Birth Fractures and Epilepsy".

P. 332



ROCK SLEYSTER, M.D.

Wauwatosa, Wisconsin

University of Illinois, College of Medicine, 1902

President-Elect, American Medical Association.

P. 332



RALPH M. TYSON, M.D.

Philadelphia

Jefferson Medical College 1915

Pediatrician to the Pennsylvania Hospital; Visiting Medical Chief, St. Christopher's Children's Hospital.

P. 332



FRANKLIN F. SNYDER, M.D.

Chicago

Johns Hopkins University, School of Medicine, 1923

Assistant Professor of Obstetrics and Gynecology, University of Chicago, and the Chicago Lying-In Hospital.

P. 332



WILLIAM I. WATSON, M.D., F.A.C.S.

New York

Cornell Medical School 1925

Attending Surgeon, Memorial Hospital. Member American Radium Society.

P. 332

Guest speakers—continued

W. OSLER ABBOTT, M.D.

Philadelphia

University of Pennsylvania 1928.

Associate in Medicine at the University of Pennsylvania; Physician to the Gastro-Intestinal Section of the Hospital of the University of Pennsylvania; Associate Ward Physician of the Hospital of the University of Pennsylvania.

P. 334

JOSHUA W. DAVIES, M.D.

New York

George Washington University 1922.

Junior Surgeon, Woman's Hospital; Anatomical Instructor, Columbia University; Associate Obstetrician, Knickerbocker Hospital.

P. 334

YALE KNEELAND, JR., M.D.

New York City

Columbia University, College of Physicians and Surgeons 1926.

Associate in Medicine at the College of Physicians and Surgeons, Columbia University; Assistant Attending Physician, Presbyterian Hospital.

P. 333

HOBART A. REIMANN, M.D.

Philadelphia

University of Buffalo School of Medicine 1921.
Professor of Medicine, Jefferson Medical College.

P. 333

NATHAN B. VAN ETEN, M.D.

New York

Bellevue Hospital Medical College 1890.

Past Speaker, House of Delegates of the American Medical Association. Lecturer on Medical Economics.

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SCIENTIFIC EXHIBITS—1939

ARRANGED BY THE SUB-COMMITTEE TO THE STANDING COMMITTEE ON
THE ANNUAL MEETING

ASHER YAGUDA, M.D., Chairman

Breast Deformities; History, Surgical Indications
and Procedures

Dr. Jacques Maliniac, Newark, N. J.

The Relation of the Corpus Luteum Hormone to
Chronic Cystic Mastitis

Dr. Charles F. Geschickter, Johns Hopkins Hospital, Baltimore, Md.

Plastic Surgery

Dr. Julius Newman, Newark, N. J.

Dysentery, Enteritis and Diarrhea; New Concepts
of Intestinal Infection

Dr. Joseph Felsen, Bronx Hospital, New York, N. Y.

Rhythms of Tumor Growth and Recession

Dr. Milton Friedman, Newark, N. J.

Studies of Normal and Pathological Conditions of
the Genito-Urinary Tract

Drs. S. R. Woodruff and J. S. Grewal, Bayonne Hospital, Bayonne, N. J.

The Practical Value of Endometrial Studies in Gynecological Disorders

Dr. Daniel R. Mishell and Dr. Leon Motyloff, Woman's Hospital, New York, N. Y.

Chronic Pulmonary Disease

Dr. M. James Fine, Newark City Hospital and Department of Health, Newark, N. J.

Rhythmic Surgery—Its Application in the Operating Room

Drs. W. H. Lawrence and C. H. Berry, Summit Medical Group, Summit, N. J.

Peripheral Vascular Disease

B. T. Horton, M.D.; Charles Sheard, Ph.D.; M. M. D. Williams, Ph.D.; and E. J. Baldes, Ph.D., The Mayo Foundation, Rochester, Minn.

What the General Practitioner Should Know About Tuberculosis

Drs. B. S. Pollak and B. P. Potter, Hudson County Tuberculosis Hospital, Jersey City, N. J.

Social Aspects of Chronic Rheumatism

Drs. Edward F. Hartung and Margaret Straub Neil, New York Post-Graduate Medical School and Hospital, New York, N. Y.

Shock: Its Mechanism and Pathology

Dr. Virgil H. Moon, Jefferson Medical College, Philadelphia, Pa., and Dr. David R. Morgan

Cardiovascular Renal Disease

Drs. F. W. Konzelmann, W. I. Lillie, E. Weiss, L. W. Smith, E. S. Gault, Temple University Medical School, Philadelphia, Pa.

Sulfanilamide and Sulfapyridine

Drs. E. A. Horowitz and A. Silver, Beth Israel Hospital, New York, N. Y.

Occupational Dermatoses

Dr. Louis Schwartz, U. S. Public Health Service, Washington, D. C., and Dr. Marion B. Sulzberger, New York, N. Y.

Non-Tuberculous Chest Conditions

a. Spontaneous Pneumothorax
b. Acute Respiratory Infections

Drs. L. S. Ylvisaker, H. B. Kirkland, and C. E. Kiessling, Newark, N. J.

New Jersey Formulary Preparations

Joint Committee on Professional Relations of The Medical Society of New Jersey and the New Jersey Pharmaceutical Association, Trenton, N. J.

Silver Picrate in the Control of Bacterial, Yeast and Protozoan Infections

Drs. John D. Corbit and Herman A. Shelanski, Philadelphia General Hospital and University of Pennsylvania, Philadelphia, Pa.

Case Finding Through Mass Tuberculin Surveys—High School Findings

Dr. Abraham E. Jaffin, Hudson County Tuberculosis Clinics, Jersey City, N. J.

Roentgen Diagnosis and Treatment of Various Intrathoracic Lesions

Dr. Raphael Pomeranz, Newark, N. J.

Selective Sterilization for Human Betterment

Sterilization League of New Jersey, Princeton, N. J.

Devereux Schools

Berwyn, Pa.

Maternal Welfare in New Jersey

Committee on Maternal Welfare of The Medical Society of New Jersey

Incidence and Treatment of Varicose Veins

Stuart Z. Hawkes, Presbyterian Hospital, Newark, N. J.

Splenomegaly

Dr. S. A. Goldberg, Presbyterian Hospital, Newark, N. J.

Internal Fixation of Fracture of the Neck of Femur

Drs. Irving Fort and John J. Flanagan, Presbyterian Hospital, Newark, N. J.

Gastro-enterological Problems

Dr. Manfred Kraemer, Presbyterian Hospital, Newark, N. J.

Treatment of Diabetes Mellitus with Diet and Insulin

Drs. B. Saslow, G. Fissell, W. Ward, and G. Kaegi, Presbyterian Hospital, Newark, N. J.

Diagnosis and Treatment of Pneumonia

Drs. Charles Rathgeber, Joseph Sorett, and S. A. Goldberg, Presbyterian Hospital, Newark, N. J.

Carcinoma of the Colon and Rectum

Drs. Edward W. Sprague and D. D'Alessandro, Presbyterian Hospital, Newark, N. J.

Diverticulitis and Diverticulosis

Drs. Royal A. Schaaf and D. D'Alessandro, Presbyterian Hospital, Newark, N. J.

Organization and Management of a Medical Group

The Summit Medical Group, Summit, N. J.

Juvenile Hypopituitarism and Hypogonadism

Drs. Rita Finkler, Sidney Keller, B. Rothhouse, R. Bass, E. Ward, Z. Marx, and G. M. Cohen, Beth Israel Hospital, Newark, N. J.

The Respiratory Defense Mechanism: Its Relationship to Pulmonary Diseases

Dr. Irving I. Applebaum, Newark, N. J.

Acute Hemolytic Anemia Following Treatment of Pneumonia with Sulfanilamide

Drs. Irving Applebaum and H. Goldberg, Beth Israel Hospital, Newark, N. J.

The Heart in Obesity

Drs. James J. Short and S. W. Kalb, New York Post-Graduate Medical School and Hospital, New York, N. Y.

Occupational Diseases

New Jersey Association of Industrial Physicians and Surgeons, Newark, N. J.

A Study of Periodic Health Examinations

Drs. Harry J. Johnson, James J. Short, J. R. Crawford, and the Life Extension Institute, New York, N. Y.

Infertility in the Male, Clinical and Surgical Treatment

Dr. Robert Hotchkiss, Cornell Medical College, New York; Dr. Henry Sangree, University of Pennsylvania, Philadelphia, Pa., and Dr. Adelaide Curtis, Women's Medical College, Philadelphia, Pa.

Peripheral Vascular Disease, Diagnosis and Treatment

Dr. Benjamin Jablons, New York, N. Y.

Pulmonary Tuberculosis and Chronic Non-tuberculous Bronchopneumonia

Dr. F. M. McPhedran, The Germantown Hospital, Philadelphia, Pa.

Public Health Program in New Jersey

Committee on Public Health of The Medical Society of New Jersey

Resolving Pneumonia Simulating Tuberculosis on the Roentgenogram

Drs. B. S. Pollak and Samuel Cohen, Medical Center—Hudson County Tuberculosis Hospital, Jersey City, N. J.

Sphincter of Oddi: Experimental and Clinical Studies

Drs. Ralph Colp, Henry Doubilet, and I. E. Gerber, The Mount Sinai Hospital, New York, N. Y.

Pelvic Structures Frequently Damaged by Labor

Dr. Joshua W. Davies, Woman's Hospital and Department of Anatomy, Columbia University, New York, N. Y.

Mechanism and Control of Hemorrhage

Drs. Arthur Steinberg, W. R. Brown, E. A. Schumann, C. T. Beecham, and H. Segal, Kensington Hospital for Women, Philadelphia, Pa.

Fresh Pathology Exhibit

New Jersey Pathologists

Scientific Motion Picture Theatre

Program to be announced later.

TECHNICAL EXHIBITS AT THE ANNUAL MEETING

Booth 1—Coca-Cola Company—Coca-Cola will be served to the delegates with the compliments of The Coca-Cola Company.

Booth 1—C. B. Fleet Company, Inc., will exhibit *Phospho-Soda* (Fleet), a highly concentrated and purified, aqueous solution of sodium phosphates, which is indicated for hepatic dysfunction, and for its thorough eliminating and cleansing action on the upper and lower gut.

Booth 2—Jones Metabolism Equipment Company presents the most modern metabolism apparatus on the market. The Jones *Motor-Basal* eliminates corrections for barometric pressure and room temperature, and eliminates calculations. It is so simple that anyone can learn to run it in a short time, and yet is accurate enough to meet the most exacting requirements of research laboratories. An exclusive geometric device checks the accuracy of each test, thus eliminating the possible error caused by the human element.

Booth 3 and 4—Mead Johnson & Company are displaying three new Mead products: Mead's *Thiamin Chloride Tablets*; Mead's *Cevitamic Acid Tablets*; Mead's *Nicotinic Acid Tablets*. *Olac* for feeding prematures is also shown, as well as the complete line of Mead's Infant Diet Materials.

Booth 5—R. B. Davis Co. invites you to enjoy a drink of delicious *Cocomalt* as its exhibit. It has a rich content of vitamins A and D, calcium and phosphorus to aid in the development of strong bones and sound teeth; iron for the blood; protein for strength and muscle; and carbohydrate for energy.

Booth 6—Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent. Our representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Booth 8—Eli Lilly and Company, of Indianapolis, will feature an eight-foot exhibit stressing the importance of *liver extract* in the treatment of pernicious anemia; *Merthiolate* (Sodium Ethyl Mercuri Thiosalicylate, Lilly) in the surgical and germicidal fields; *Sodium Amytal* (Sodium Iso-amyl Ethyl Barbiturate, Lilly) in the field of hypnotics; and *Insulin* (Insulin, Lilly) in the management of diabetes mellitus. This is the first appearance of the Lilly Research Laboratories at the meeting of the State Medical Association of New Jersey, and the exhibit unit has been specially designed for state medical meetings.

Booth 9—The Mennen Company will exhibit their two baby products—*Antiseptic Oil* and *Antiseptic Borated Powder*. Register at the Mennen exhibit and receive your kit containing demonstration sizes of their shaving and after-shave prod-

ucts; also, for the lucky number prize drawing to be held at the close of the convention for *De Luxe Fitted Leather Toilet Kits*.

Booth 10—The Arlington Chemical Company again will exhibit, featuring their biological and pharmaceutical products. It is offering a \$9.75 diagnostic protein outfit containing eighty common offenders; a \$1.00 diagnostic pollen outfit; and a full line of proteins and pollens for diagnosis and desensitization. Its representatives will be glad to discuss any allergic problem.

Booth 11—Faulhaber & Heard—Any member who desires information in connection with professional liability protection, a feature of membership, can obtain full particulars at Booth No. 11, maintained by Faulhaber & Heard, Inc., the Official Broker of The Medical Society of New Jersey. Ninety per cent of the members have taken advantage of this contract. This is evidence of the benefits derived by having their protection in the company that has served the Medical Society since 1921.

Booth 12—The Cameron Surgical Specialty Company—The new and inexpensive models of Cameron *Cauterodyne* (Radio Frequency), providing safe and effective cutting, coagulation, desiccating and fulgurating with a quick-healing, bloodless field for all classes of surgery. Latest developments in electrically lighted lamps and instruments for all phases of surgery and diagnosis will also be demonstrated. See the new *De Luxe Rectal Diagnostics*.

Booth 13—Lederle Laboratories will feature its *Pneumonia Products* for Diagnosis and Therapy, one c.c. Concentrated Solution *Liver Extract* and all Allergenic products including *Hay Fever* and *Poison Ivy Antigens*.

Booth 14—Reed & Carnrick—The first firm to manufacture endocrine products in the United States was Reed & Carnrick, established in 1860. It still continues to produce endocrine products of the highest character. Its advertising is solely to the physicians, and its products are sold on prescription.

The leaders are the *Estrogenic Hormone* in oily solution and tablet form, *Nephritin* for renal conditions, *Peptenzyme*—digestive tablets, *Protonuclein* for stepping up metabolism, *Tonicine Male* and *Tonicine Female*—tonics, *Ovacoids*, *Testacoids* and *Ampacoids* Ovary and Testicle for gonadal disturbances, *Endomin* for anemia, *Pancrobilin* for constipation, and *Entacarb* Powder and tablets for alkalization.

As usual, Mr. and Mrs. Walter J. Gaskell will be in charge of the exhibit.

Booth 15—The Chas. H. Phillips Chemical Co. is the maker of *Phillips' Milk of Magnesia*, the standard of quality for more than half a century, and of *Phillips' Milk of Magnesia Tablets*.

Booth 15-A—National Casualty Company—

Since the adoption by the Society at the last Annual Meeting of the new and improved group accident and health insurance plan there has been a greater increase in the number of insured members than in any similar period in the last twelve years that group accident and health insurance has been in effect.

As further proof of the broad coverage provided by the new policy, this plan has also been adopted by the New Jersey State Dental Society, and in New York by the Westchester and Bronx County Medical Societies.

For literature and information regarding this policy, stop at the exhibit of the National Casualty Company, in charge of E. and W. Blanksteen of Jersey City, the Society's authorized accident and health insurance representative.

Booth 16—Kalak Water Company—Visit this

booth and ask the representative there to explain how *Kalak Water* may be used to buffer the untoward effects of sulfanilamide or sulfapyridine.

Booth 17—The Doho Chemical Corporation,

New York, will exhibit a new preparation for the osmo-therapeutic treatment of otitis media.

The *Auralgan* exhibit shows anatomical picture of the ear and the process of osmotic action, together with many slides in color pertaining to diseased drum membranes; also corrosion, maceration and obscured landmarks resulting from the use of phenol glycerin. *Auralgan* is used in place of phenol glycerin, but contains no phenol.

Booth 19—The Picker X-Ray Corporation will

show its *Century Unit*—a *Shock-proof Self-contained Radiographic and Fluoroscopic Apparatus*, typical of the Picker line. It has a capacity of 100 M. A. at 100 P. K. V., with tilting table which provides for fast radiography and fluoroscopy in all positions from the vertical to the Trendelenberg.

A double focus oil immersed tube, and a motor-driven fractional-second timer, facilitate fast chest radiography at six feet.

Booth 20—Liebel-Flarsheim, Cincinnati, Ohio,

will exhibit a complete line of the well-known *L-F Short Wave Generators*, as well as the famous *Bovie Electro-Surgical Units*. In addition, other new and useful physiotherapy apparatus will be shown.

Booth 21—Lea & Febiger—Among the new

books which Lea & Febiger will exhibit are Stimson's "*A Manual of Fractures and Dislocations*"; Miller's "*Applied Anatomy*"; Cowan's "*Refraction of the Eye*"; Schlanser's "*Practical Otology, Rhinology and Laryngology*"; Thorndike's "*Athletic Injuries*"; and Brenner's "*Pediatric Surgery*". New editions will be shown of MacKee on X-Ray Therapy, Pohle on Theoretical Principles of Roentgen Therapy and Clinical Roentgen Therapy; Crotti on Diseases of the Thyroid, Parathyroids and Thymus; Kovacs on Electrotherapy and Light Therapy; Ivy & Curtis on Fractures of the Jaws; Brown

on Oral and Facial Diseases and Malformations; and Kanavel on Infections of the Hand.

The exhibit will be in charge of Mr. Phillip Gots.

Booth 22—The Cameron Heartometer Company

will exhibit the new *Heartometer*, a scientific precision instrument for permanent recording of a perfect pulse count, and an accurate systolic and diastolic blood pressure reading. It also produces a graph which records the condition of the nerves, valves, and muscle of the heart, showing many heart disorders in their earliest and advanced stages.

Booth 23—Denver Chemical Mfg. Co. will ex-

hibit *Antiphlogistine*. This product is employed by physicians everywhere in the treatment of inflammatory and congestive conditions. *Galatest*, a new micro-reagent for the instantaneous detection of urine sugar, will also be demonstrated. Physicians are cordially invited to visit the exhibit.

Booth 24—E. R. Squibb & Sons, New York,

will exhibit the complete line of Squibb Vitamin, Glandular, Arsenical and Biological Products and Specialties; and also a number of interesting new items.

Well-informed Squibb representatives will be on hand to welcome you, and to furnish information regarding the products displayed.

Booth 25—Davies, Rose & Company, Limited,

Boston. The preparations that this firm is showing have a world-wide reputation. Physiological or chemical tests are made to assure their standardization. Clinical experience vouches for their dependability.

Messrs. F. L. Moulton and H. V. Orne, who are well known to many of the medical practitioners of New Jersey, will be at the booth to welcome visitors.

Booth 26—John Wyeth & Brother, Inc., Phila-

delphia, Pa., will display a number of its pharmaceutical specialties including: *Kaomagma*, an intestinal adsorbent; *Amphojel*, Wyeth's *Alumina hydroxide gel* for the treatment of gastric hyperacidity and peptic ulcer; *Silver Picrate*, for use in the treatment of *Trichomonas vaginitis*; *Bewon Elixir*, a palatable dosage form of crystalline vitamin B; *Mucara*, a karaya gum product for habitual constipation; and other preparations of interest to both general practitioner and specialists.

Booth 27—Jetter & Scheerer Products, Inc.,

New York City, will exhibit its world-famous line of Jetter & Scheerer *Surgical Instruments* again this year. A large variety of both *Rustless Steel* and *Chrome Plated* instruments will be displayed, including many unusual and special items. This line has been held in highest esteem by surgeons since 1867, and is still considered to be the "standard" for which all others aim. You are cordially invited to visit our booth.

Booth 28—Gerber Products Company invites

your inspection of its new Cereal Food,—a dry, pre-cooked—a combination of cereals, supplemented

with mineral and vitamin containing foods. Both professional literature and booklets for mothers are available to you.

Booth 29—Parke, Davis & Company—Members of the staff of Parke, Davis & Company will be at your service to tell you about some of its research staff's numerous scientific accomplishments. *Mapharsen*, *Adrenalin*, *Pitocin*, *Pitressin*, *Theelin*, *Theelol*, and biological products will be a part of this attractive exhibit.

Booth 29-A—The Radium Chemical Company, Inc., cordially invites physicians to visit its exhibit of instruments for the handling and application of radium and radon, including some attractive new features that will be explained. Representatives in attendance will be prepared to discuss with physicians their radium and radon requirements, and to outline a leasing service whereby physicians may obtain continuous possession of any desired quantity of radium at a nominal monthly fee, with no capital investment involved.

Booth 30—The Burroughs Wellcome & Co. presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession.

Booth 31—Petrolagar Laboratories, Inc. offers, in addition to samples of the five types of *Petrolagar*, an interesting selection of descriptive literature and anatomical charts. Ask the Petrolagar representative, Mr. D. S. Vervoort or Mr. L. J. Eyskens, to show you the new *Habit Time* booklet. It's a welcome aid for teaching bowel regularity to your patients.

Booth 32—Horlick's Malted Milk Corporation—Nourishing, digestible, appetizing—these are the three outstanding qualities for which *Horlick's* is famous, whether in powder or tablet form. Visit the exhibit and see the many uses from infant feeding to old age. Note especially the convenience of the tablets in ulcer diets.

Booth 33—The Wander Company—Whenever you feel tired or "on edge", have a refreshing cup of *Ovaltine* at The Wander Company's exhibit. *Ovaltine* is a protective food supplement which contains vitamins A, B, D, and G, and the minerals calcium, phosphorus, copper and iron. It is used as a building food for children and adults, in convalescence, for expectant and nursing mothers, and as an aid to sleep. You may feel free to visit the *Ovaltine* booth frequently.

Booth 34—Walker-Gordon Laboratory Co.—As usual *Walker-Gordon Certified*, *Vitamin D* and *Acidophilus Milks* will be available at the Walker-Gordon exhibit. Representatives of the company will be very glad to give members of the Medical Society whatever information they may desire regarding new developments in high quality milk production.

Booth 34—The C. V. Mosby Company—Among the many new important books to be displayed by the C. V. Mosby Company are Brickel, "Surgical Treatment of the Infections of the Hand and Forearm"; Behan's "Cancer"; the second edition of Gradwohl's "Clinical Laboratory Methods and Diagnosis"; the second edition of Meakin's "Practice of Medicine"; and the second edition of Watson's "Hernia". Approximately 150 other new and standard works will complete the exhibit.

Booth 36—The Borden Co.—Already remarkably successful in infant feeding, *Biolac* is exhibited for the first time in New Jersey at the Borden exhibit. Competent representatives will gladly provide specific, helpful information on the unique virtues of this *liquid*, modified milk.

Also exhibited are other Borden products, notably Dryco, Special Dryco, Klim, Beta Lactose, Merrell-Soule Products, and Borden's Irradiated Evaporated Milks.

Booth 37—Professional Electro-Medical Co., Newark, N. J., will display a full line of *Lepel* electro-medical equipment. A special feature will be a new type tube operated short wave unit, giving measured dosage,—a unique feature of *Lepel* equipment,—as well as a new combination fluoroscopic unit with portable x-ray features.

Booth 38—A. C. Barnes Co., Inc., New Brunswick, N. J. It is strange, but true, that the chemists of the world, who usually duplicate almost everything, have not yet succeeded in duplicating *Argyrol*, perfected almost thirty-eight years ago by a physician. At the A. C. Barnes exhibit the numerous chemical and clinical superiorities of *Argyrol* over all other mild silver proteins, and of *Ovoferin* over other iron preparations, are visually demonstrated.

Booth 39—S. M. A. Corporation—Among the technical exhibits at the convention this year is an interesting new display, which represents the selection of infant feeding and vitamin products of the *S. M. A. Corporation*. Physicians who visit this exhibit may obtain complete information, as well as samples, of *S. M. A. Powder*, and the special milk preparations—Protein S. M. A. (Acidulated), *Alerdex*, and *Hypo-Allergic Milk*.

Booth 40—The Radium Emanation Corporation will exhibit a wide variety of instruments and applicators used in modern radium therapy, including permanent and removable composite, leakproof *Radon Seeds*. The advantages of these seeds will be demonstrated by magnified sections showing their constructions in detail.

Booth 41—H. J. Heinz Company will display *Heinz Junior Foods*, a new variety for older babies. The Heinz representative is ready to assist you to inspect this new product, as well as the *Heinz Strained Foods*.

Register at the Heinz booth for helpful literature.

WELFARE COMMITTEE

The fifth and last of the regular meetings of the Welfare Committee that were announced in The Journal of June, 1938, was held in the Hotel Hildebrecht, Trenton, N. J., on April 16, 1939. Those who registered their attendance were as follows:

WELFARE ATTENDANCE—APRIL 16, 1939

Atlantic County—

Hilton S. Read, Chairman
William J. Carrington, Ex-Officio
David B. Allman Robert A. Kilduffe

Bergen—

G. Barton Barlow Spencer T. Snedecor

Camden—

R. L. Sharp George B. German

Cape May—Clarence W. Way

Cumberland—

Harry B. Walker Leslie E. Myatt
Millard F. Sewall

Essex—

Alfred Stahl, Ex-Officio
Arthur W. Bingham Julius Levy
Edgar P. Cardwell A. Charles Zehnder
Harry N. Comando Frank A. Bien
J. Irving Fort

Gloucester—

Chester I. Ulmer Wendall Burkett

Hunterdon—Barclay S. Fuhrmann

Hudson—

A. E. Jaffin B. S. Pollak
William W. Maver Joseph F. Londrigan
James F. Norton

Mercer—

D. Leo Haggerty Charles H. Mitchell

Middlesex—

George W. Fithian Jacob J. Mann
Joseph H. Kler

Monmouth—

William G. Herrman Stanley Nichols
Barclay W. Moffat

Morris—Byron G. Sherman

Passaic—

Wright MacMillan J. Allen Yager

Somerset—Frank L. Field

Union—

Norman W. Burritt Herschel S. Murphy
Frederic W. Lathrop

Warren—William H. Varney

Advisory—

William H. MacDonald
Robert P. Fischelis
Frederic J. Quigley
LeRoy A. Wilkes, Secretary
Frank Overton, Editor

Also present were:

J. Howard Hornberger, Burlington
E. Zeh Hawkes, Essex
William H. Costello, Morris
Andrew F. McBride, Passaic
Watson B. Morris, Union
Samuel Alexander, Bergen

Thomas B. Lee, Camden
Walter B. Stewart, Atlantic
Clyde M. Fish, Atlantic
T. R. Robie, Essex
M. L. Weimann, Camden
H. Wesley Jack, Camden
Reeve L. Ballinger, Essex
Robert M. Grier, Atlantic
L. Samuel Sica, Mercer
L. B. Drake, Sussex
Samuel B. English, Hunterdon
Clarence L. Andrews, Atlantic
Robert S. Gamon, Camden
Augustus S. Knight, Somerset
R. A. MacKenzie, Monmouth
Walter B. Mount, Essex
E. S. Sherman, Essex
Joseph R. Morrow, Bergen
(Mr.) Donald Benson, Middlesex (Public Relations Department)

SUB-COMMITTEES AND ADVISORY COMMITTEES

The general meeting was preceded by a meeting of each sub-committee and advisory committee, in accordance with the schedule announced in the February Journal, page 117. This plan was carried out with success. The annual report of practically every chairman of a committee had been submitted to the Executive and Editorial offices. They had been set in type, and a full set of proofs had been provided so that every member of each committee had a copy. The reports were considered by the several committees, and their suggestions were noted. By this method every report of a chairman was considered by his committee with the surprising result that the reports were shortened and made more concise, rather than lengthened. The edited reports are printed on pages 257 to 330 of this Journal.

DINNER MEETING

At 12:30 o'clock the members of the committees assembled for luncheon, after which the Welfare Committee held its formal meeting. Chairman H. S. Read being called away, Past President S. T. Snedecor presided.

PRESIDENT CARRINGTON'S ADDRESS

President William J. Carrington read his annual report, in which he reviewed the progress of the Society during the past year. This address is printed on page 257 of this Journal.

The guest speaker was Dr. J. A. Hannah, Toronto, who described the workings of the Associated Medical Services, Inc., of the Ontario Medical Association. An abstract of his address will be printed in the June Journal.

THE ANNUAL DINNER DANCE

The President's Dinner Dance at the coming Annual Meeting in June will be the biggest and best yet held. Every seat will be *reserved*, and those wishing to sit together will please send in their reservations by mail now for the best tables, or make arrangements immediately on arrival at Haddon Hall. Assessment \$3.00 per ticket.

Near the Registration Desk there will be a *Reservation Table* where seating arrangements will be made. *The best locations will be assigned first.*

No speeches. Only brief greetings from the President, President-Elect, and the President of the Woman's Auxiliary. Good music for dancing, and entertainment by the "Kiwanis Band Wagon" of Atlantic City.

Everyone will want to show "Bill" Carrington that his earnest efforts and fine leadership throughout this year have been appreciated. Here is *your* opportunity. Send in your reservation *now!*

Use the order card in the center of this Journal.

THE VOTE ON THE MEDICAL PRACTICE ACT

The Medical Practice Act,—A-210,—passed the Assembly on April 17 by a vote of 38 for, and 16 against. The Clerk of the Assembly, Mr. Paul Williams, has supplied Dr. B. S. Pollak, Chairman of the Committee on Legislation, with a list of the Assemblymen who voted for the bill, and those who voted against it. The list is as follows:

Voted in favor of the Act:

Artaserse	McClave
Beronio	McDermott
Cavicchia	Orben
Czachorowski	Palese
Devoe	Pascoe (Speaker)
Donahue	Platts
Farley	Schaeffer, G. B.
Featherer	Shepard
Freund	Sholl

Hancock	Smith
Haneman	Stokes
Hargrave	Vasbinder
Herbert	Vogel
Huntington	Wegrocki
Johnson	Wickham
Kerner	Wilensky
Lance	Williamson
Littauer	Willson, H. A.
Lum	Worrell

Voted against the Act:

Bogle	Hanna
Browne	Maloney
Cassin	Pierson
Connolly	Sanford
Doremus	Schroeder
Ferster	Shafer, C. I.
Glickenhau	Ward
Hand	Wilson, E. N.

SURVEY OF MEDICAL SERVICES

Two communications which have been received from officials of the American Medical Association demonstrate that the Survey of Medical Services made under the supervision of Assistant Executive Secretary, Norman M. Scott, M.D., is deeply appreciated.

The first communication is a telegram to President Carrington from Dr. Olin West, Secretary of the A. M. A., which reads as follows:

Dr. Leland has just shown me the splendid survey material received from you as President of The Medical Society of New Jersey. We are grateful to you and to all who collaborated with you as President of The Medical Society of New Jersey for this material, and for the helpful and kindly spirit which it represents.

The second communication is a letter to President Carrington from Dr. R. G. Leland, Director of the Bureau of Medical Economics of the A. M. A., which reads as follows:

The State report on the Study of Medical Care arrived yesterday, and I am hastening to express to you my appreciation of the very efficient, complete, and satisfactory manner in which you and your committee have undertaken and completed this work.

It must be of considerable satisfaction to you as well, to have the tremendous amount of valuable information that has resulted from this study. I have of course had no time as yet to examine the report carefully, but from a general inspection of the various titles and the treatment of each, I can state unreservedly that I am very much pleased with this material.

Please convey to those who must have worked tirelessly in the analysis of the basic data and the preparation of this report, my sincere appreciation of their efforts, and my congratulations on the final results.

EDITORIAL COMMENT

A survey of medical services naturally consists of two parts:

1. The personal services rendered by each physician.
2. Public records of public health services, and the conditions which they are designed to meet.

PERSONAL SERVICES

The survey of his personal services has had an effect on each physician similar to that of his income tax return. Each requires the doctor to estimate his opportunities and his resources,—the one of his financial affairs, the other of his professional services to the people. A conscientious study of his practice will lead each physician to substitute a degree of certainty for his emotional opinions. The response of only ten per cent of the doctors makes the survey worth while. As a matter of fact, the percentage of replies has shown that one-third

of the doctors gave serious thought to the problem.

PUBLIC RECORDS

The survey conducted by Dr. Scott has revealed a varied amount of records which were unsuspected. Take for example, the number of doctors' prescriptions which are filled annually by pharmacists. Every drug store is compelled to report to the State Board of Pharmacy the number of doctors' prescriptions which it has filled. The State records reveal the surprising fact that drug stores in the chain and cut-rate class put up only a very small percentage of prescriptions written by doctors; and that the one-man and two-man stores still do a surprisingly large percentage of the business of legitimate dispensing of drugs. This fact is to be seriously considered by the Committee on Pharmaceutical Relations of The Medical Society of New Jersey.

CONCLUSION

When one considers the fact of the newness and novelty of the survey, the conclusion is inevitable that it has been well worth while, and that it should develop into an annual project.

THE MEDICAL SOCIETY AT WORK

This May issue of the Journal is an unexpected demonstration of the greatly increased scope of the activities of The Medical Society of New Jersey, and of the county societies, during the administrative year that is now nearing its close.

OBJECTIVE

The dominant objective of the Journal is to report the activities of the medical profession of New Jersey as an *organized entity*. Governmental participation in the distribution of medical services is now a *fact*, and not a mere *theory*; and the most active opponents of "State Medicine" demand pay for their services to the indigent and low-wage group. It is up to The Medical Society of New Jersey and each of its twenty-one county societies to assume the leadership in developing a system of coöperation with welfare and governmental groups, local, State, and nation-wide.

How far the official medical societies of New Jersey have already progressed in their administration projects is revealed in the current issues of the Journal during the past year; and more striking in this its May issue.

1. ATTITUDE OF ADVERTISERS

The attitude of advertisers is an index of lay opinion toward organized medicine. Last year advertisers clamored for space in the Journal containing the *Annual Reports*; and this year the demand has been far greater. It is to the financial interest of the Society to accede to these demands, even though some of the usual departments are omitted.

However, in order to compensate for a temporary disarrangement of the contents of the Journal, the Publication Committee plans to place the June issue in the mail on or before June first, so that the members will receive it before they start for the annual meeting.

2. THE ANNUAL REPORTS

To publish the annual reports of the officers and committees of the State Society requires a 40 per cent increase in the amount of space assigned to them. At the same time the reports are written more clearly and concisely than ever before.

In attaining this desirable result a great factor was the meeting of each committee on April 16 to discuss the proposed report of its

chairman. Each proposed report was in the form of a printed galley proof-sheet, a copy of which was given to every member of the committee. The surprising result was that each committee edited the report of its chairman, thereby reducing its size, and at the same time, increasing its conciseness and readability, and its adaptation to intelligent discussion in the House of Delegates.

3. REPORTS FROM COUNTY SOCIETIES

A new feature of the annual reports was an invitation to the President of each county society to prepare a report of the activities and objectives of his organization. This feature was introduced in recognition of the essential importance of the county society as a component element of the State Society. The response of the county societies was gratifying,—60 per cent of the societies responding, representing 85 per cent of the membership of the State Society.

4. PREPARATION FOR THE ANNUAL MEETING

This May issue of the Journal is essentially a *fore-word* to the annual meeting, when the events of the past year will be reviewed, and plans will be authorized for their expansion during the coming year. The whole history of The Medical Society of New Jersey has been one of constant *evolution*. While our forefathers took their time in deciding on a new course of action, yet only seldom did they reject a plan that was seriously proposed by their thoughtful leaders. The germs of practically every one of the modern projects of the State Society may be clearly traced to their beginnings a half century or a century ago. The events of the past year, as revealed in the annual reports, are *landmarks of progress* in keeping with the methods established by former leaders, throughout the 173 years of life of The Medical Society of New Jersey.

STOLEN GOODS

This Journal has received the following letter from Dr. T. P. Thompson, Aberdeen, Maryland:

On Friday, April 7th, between the hours of 11:45 a. m. and 2 p. m., my office was broken into and the following items stolen:

1. A new Spencer microscope without case with A. S. Aloe, St. Louis, Mo., nameplate single body tube, chromium trim, scope No. 147810 with objective numbers as follows:
 - 16 mm No. 368808
 - 4 mm No. 366018
 - 1.8 mm No. 371424

2. An Underwood Portable Typewriter, No. 4B-155109, green and black trim with black painted outside case.

I have reason to believe that these were stolen by a drug salesman—hence his outlet would be a physician who might unthinkingly believe his story as to why he had them for sale.

If any member is solicited to buy a second-hand microscope or typewriter, check up their numbers, and note whether or not the identifying marks have been erased. Inform the Journal of any clues you may discover.

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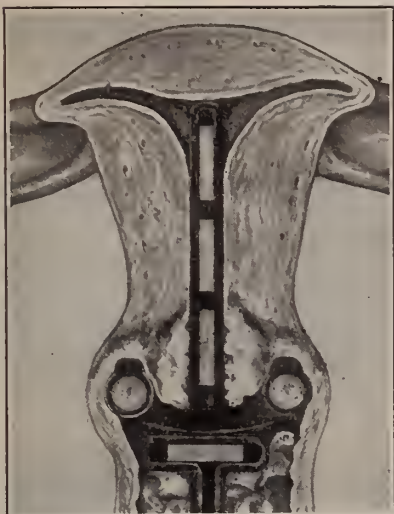
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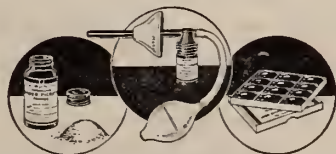
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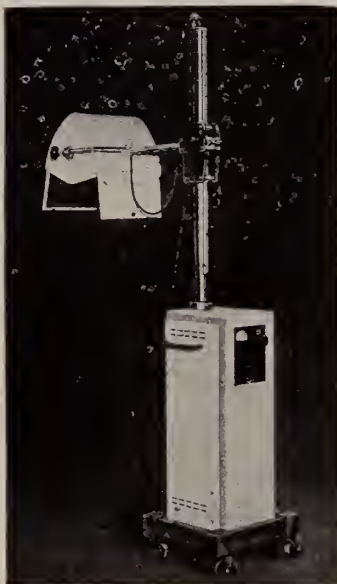
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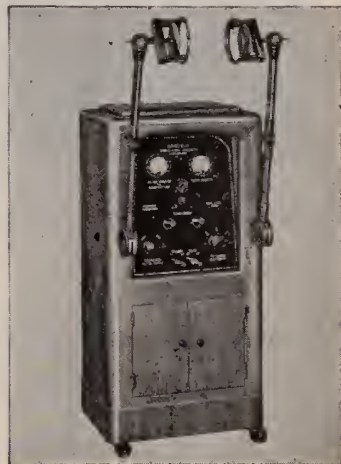
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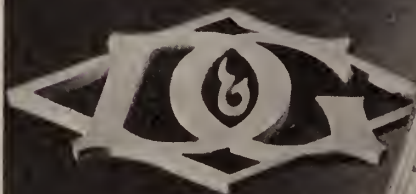
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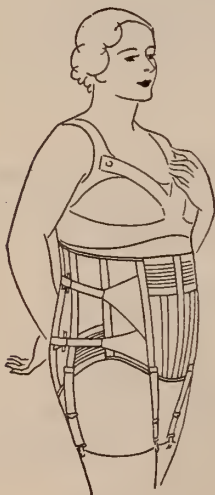
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Trenton.....June 5, 1938.....11 a. m.
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Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
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Trenton.....Feb. 19, 1939.....11 a. m.
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WILLIAM GETTIER HERRMAN, *Chairman* Asbury Park
HENRY BOYLAN ORTON, *Vice-Chairman* Newark
HAROLD STERN DAVIDSON Atlantic City
ELLWOOD EMERSON DOWNS Woodbury
JOHN BUTLER FAISON Jersey City
OTTO RUDOLPH HOLTERS Asbury Park
JOSEPH HENRY KLER New Brunswick
AUGUSTUS S. KNIGHT Far Hills
CHARLES B. WOODMAN Morristown
THOMAS BENJAMIN LEE, *Consultant* Camden

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Child Health

STANLEY NICHOLS, *Chairman* Long Branch
WALTER BLAIR STEWART, *Vice-Chairman* Atlantic City
ARTHUR FOWLER ACKERMAN Summit
CHESTER BROWN Arlington
ERNEST GARFIELD HUMMEL Camden
IRVING OKIN Passaic
LOUIS CHARLES ROSENBERG Newark
ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Conservation of Vision

ELBERT STETSON SHERMAN, *Chairman* Newark
CHARLES H. SCHLICHTER Elizabeth
ELIAS J. MARSH Paterson
WALLACE PYLE Jersey City
JOSEPH HENRY KLER New Brunswick

Constitution and By-Laws

JAMES FRANCIS NORTON, *Chairman* Jersey City
DAVID KRAKER, *Vice-Chairman* Newark
HERBERT WILLIAM NAFAY New Brunswick
GEORGE N. J. SOMMER Trenton
DAVID H. BARTINE ULMER Moorestown
FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.

Contract Practice

REUBEN LORE SHARP, *Chairman* Camden
L. SAMUEL SICA, *Vice-Chairman* Trenton
FRANK WILLIAM ASH Paterson
JOHN GEORGE DECKER Hasbrouck Heights
HENRY HAYWOOD New Brunswick
HARVEY THEODORE HEROLD Newark
EDWARD FREDERICK KLEIN Perth Amboy
JENNINGS HOWARD HORNBERGER, *Consultant* Roebbing
ANDREW C. RUOFF Union City

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Crippled Children

BABCLAY WELLINGTON MOFFAT, *Chairman* Red Bank
ELMER PETER WEIGEL, *Vice-Chairman* Plainfield
OSWALD RUDOLPH CARLANDER Camden
FREDERICK GEORGE DILGER Hackensack
WILLIAM GREENFIELD Hackensack
EMANUEL HARRISON NICKMAN Atlantic City
TOUFICK NICOLA Montclair
HERBERT WILLIAM NAFAY, *Consultant* New Brunswick

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Finance and Budget

HARRY ROSS NORTH, <i>Chairman</i> (1939)	Trenton
HERSCHEL PETTIT (1942)	Ocean City
WELLS PHILLIPS EAGLETON (1943)	Newark
ANDREW FRANCIS MCBRIDE (1941)	Paterson
DAVID B. ALLMAN (1944)	Atlantic City
HENRY SPENCE (1940)	Jersey City
ELIAS JOSEPH MARSH, <i>Ex-Officio</i>	Paterson

Honorary Membership

LANCELOT ELY, <i>Chairman</i>	Somerville
*EPHRAIM ROLAND MULFORD	Burlington
FREDERIC JAMES QUIGLEY	Union City

No meetings, work carried on by correspondence.

Hospital Relationships

SPENCER TREADWELL SNEDECOR, <i>Chairman</i>	Hackensack
WILLIAM H. A. WARNER, <i>Vice-Chairman</i>	East Orange
HENRY BRISTOL DECKER	Camden
FLORENTINE MILTON HOFFMAN	New Brunswick
CHARLES HYMAN	Atlantic City
ELTON WALLACE LANCE	Rahway
GEORGE O'HANLON	Jersey City
THOMAS KRAPPEN LEWIS, <i>Consultant</i>	Camden

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Industrial Injuries and Occupational Diseases

J. IRVING FORT, <i>Chairman</i>	Newark
LESLIE EDWIN MYATT, <i>Vice-Chairman</i>	Bridgeton
CHARLES LITWIN	Teaneck
TRAUGOTT JOHN SCHUCK	Hoboken
JAMES HERBERT SPENCER, JR.	Franklin
WILLIAM FRANCIS COSTELLO, <i>Consultant</i>	Dover
HENRY HOWARD KESSLER, <i>Technical Adviser</i> , representing Commissioner J. J. Toohey, N. J. Dept. of Labor.....	Newark
ROY GRIFFITH, <i>Technical Adviser</i> , representing the Manu- facturers' Association of New Jersey	Glen Ridge

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Legislation

BERTHOLD STEINBACH POLLAK, <i>Chairman</i>	Secaucus
CHARLES HENRY MITCHELL, <i>Vice-Chairman</i>	Trenton
WENDALL JONES BURKETT	Pitman
HERBERT ROY VAN NESS	Newark
WILLIAM CRANE WILENTZ	Perth Amboy
SAMUEL ALEXANDER, <i>Consultant</i>	Park Ridge

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Others at call of Chairman

Maternal Welfare

ARTHUR WALTER BINGHAM, <i>Chairman</i>	East Orange
JOHN CARLISLE BROWN, <i>Vice-Chairman</i>	Atlantic City
SAMUEL ALLISON COSGROVE	Jersey City
GEORGE BURTON GERMAN	Camden
CARL HALLER ILL	Newark
JULIUS LEVY	Newark
ROBERT ABBE MACKENZIE	Asbury Park
WALTER BARCLAY MOUNT	Montclair
JAMES HARRIS UNDERWOOD	Woodbury
HARRISON BETTS WILSON	Hackensack
THOMAS BENJAMIN LEE, <i>Consultant</i>	Camden

Meetings

Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

January, 1939, Joint Meeting with County Maternal Committees and Field Physicians; date, hour, and place to be selected by Chairman, Dr. Bingham.

Medical Care of Indigent and Low-Wage Group

GEORGE WASHINGTON FITHIAN, <i>Chairman</i>	Perth Amboy
DAVID WRIGHT GREEN, <i>Vice-Chairman</i>	Salem
FRANK L. FIELD	Far Hills
DANIEL LEO HAGGERTY	Trenton
WARREN DAVID ROBBINS	Cape May
BYRON GRANT SHERMAN	Morristown
EDWARD MATHIAS ZEH HAWKES, <i>Consultant</i>	Newark

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Medical Defense and Insurance

CHRISTOPHER CHARLES BELING, <i>Chairman</i>	Newark
JOSEPH WALLACE HURFF, <i>Vice-Chairman</i>	Newark
JOHN CHARLES MCCOY	Paterson
GEORGE THOMAS TRACY	Beverly
WILLIAM CARTER WESCOTT	Atlantic City
WELLS PHILLIPS EAGLETON, <i>Consultant</i>	Newark

Meetings

Atlantic City....May 19, 1938.....	4 p. m.
Interim meetings at the call of Chairman	
Trenton.....Apr. 16, 1939.....	4 p. m.

Medical Practice

DAVID BACHARACH ALLMAN, <i>Chairman</i>	Atlantic City
SPENCER TREADWELL SNEDECOR, <i>Vice-Chairman</i>	Hackensack
HARRY NOAH COMANDO	Newark
GEORGE WASHINGTON FITHIAN	Perth Amboy
JACOB IRVING FORT	Newark
WILLIAM WALLACE MAVER	Jersey City
REUBEN LORE SHARP	Camden
CHESTER ISAAC ULMER	Gibbstown
ANTHONY CHARLES ZEHNDER	Newark
THOMAS KRAPPEN LEWIS, <i>Consultant</i>	Camden

Meetings

Atlantic City....May 19, 1938.....	4 p. m.
Trenton.....Apr. 16, 1939.....	4 p. m.

For meeting of Advisory Committees see their schedules

Mental Hygiene

JAMES STUART PLANT, <i>Chairman</i>	Newark
MARCUS ALBERT CURRY, <i>Vice-Chairman</i>	Greystone Park
WILLIAM COLE DAVIS	Atlantic City
BARCLAY STOKES FUHRMANN	Flemington
ALLEN GILBERT IRLAND	Trenton
EDWARD SHEAFE KRANS	Plainfield
CLARENCE MORTON TRIPE	Asbury Park
HERBERT WILLIAM NAFEY, <i>Consultant</i>	New Brunswick
AMBROSE DOWD, <i>Technical Adviser</i> , representing Commis- sioner Ellis, N. J. Department of Institutions and Agencies	Newark

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

One or two other meetings at call of Chairman

Nursing and Nursing Education

ANTHONY CHARLES ZEHNDER, <i>Chairman</i>	Newark
GEORGE MILTON KNOWLES, <i>Vice-Chairman</i>	Hackensack
HORACE WESLEY JACK	Camden
VICTOR KNAPP	Asbury Park
FRANK LESLIE PERRY	Woodstown
HARRY SUBIN	Atlantic City
THOMAS J. FRANCIS WALSH	Elizabeth
WELLS PHILLIPS EAGLETON, <i>Consultant</i>	Newark

Meetings

Trenton.....June 5, 1938.....	11 a. m.
Trenton.....Oct. 2, 1938.....	11 a. m.
Trenton.....Dec. 4, 1938.....	11 a. m.
Trenton.....Feb. 19, 1939.....	11 a. m.
Trenton.....Apr. 16, 1939.....	11 a. m.

Pharmaceutical Problems

CHESTER ISAAC ULMER, *Chairman*Gibbstown
REEVE LESLIE BALLINGER, *Vice-Chairman*Arlington
JACOB JOHN MANNPertb Amboy
MERWIN LESTER HUMMELMerchantville
CHARLES JOSEPH MURNPaterson
DANIEL WOOLSEY TELLER, JR.Morristown
RALPH KING HOLLINSHED, *Consultant*Westville

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Pneumonia Control

ROBERT ANTHONY KILDUFFE, *Chairman*Atlantic City
THOMAS MICHAEL KAINCamden
HENRY PAUL DENGLESpringfield
*MARSHALL FLOWER LUMMISPitman
FREDERICK THOMAS VOSBURGHPassaic
RALPH KING HOLLINSHED, *Consultant*Westville
WILLIAM MACDONALD, *Technical Adviser*, representing
Dr. J. Lynn Mahaffey, Director N. J. Department of
HealthTrenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Post-Graduate Education

DAVID FULLER BENTLEY, *Chairman*Haddonfield
STUART ZEH HAWKES, *Vice-Chairman*Newark
ALBERT WILLIAM PIGOTTSkillman
ERNEST FRANCIS PURCELLTrenton
HAMMELL PIERCE SHIPPSDelanco
SLOAN GRIFFIN STEWARTAtlantic City
CLARENCE WILTON WAYSea Isle City
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.

Public Health

STANLEY NICHOLS, *Chairman*Long Branch
FREDERICK WILLIAM LATHROP, *Vice-Chairman*Plainfield
FRANK A. BIENIrvington
ARTHUR WALTER BINGHAMEast Orange
CHARLES BYRON BLAISDELLLong Branch
JACOB IRVING FORTNewark
ERNEST GARFIELD HUMMELCamden
ALLEN GILBERT IRELANDTrenton
ABRAHAM EZRA JAFFINJersey City
ROBERT ANTHONY KILDUFFEAtlantic City
*ISAAC WARNER KNIGHTPitman
JULIUS LEVYNewark
BARCLAY WELLINGTON MOFFATAsbury Park
HERSCHEL STRATTON MURPHYRoselle
HENRY BOYLAN ORTONNewark
JAMES STUART PLANTNewark
ELBERT STETSON SHERMANNewark
*THEODOR TEIMERNewark
EDWARD MATHIAS ZEH HAWKES, *Consultant*Newark

Technical Advisers

ELLEN POTTER and EMIL FRANKEL, representing Wm. G. Ellis,
N. J. Dept. Institutions and Agencies.
HENRY HOWARD KESSLER, representing J. J. Toohey, N. J.
Dept. of Labor.
WILLIAM MACDONALD, representing Director Mahaffey, N. J.
Dept. of Health.
HOWARD DARE WHITE, representing Director Elliott, N. J.
Dept. of Public Instruction.

Meetings

Long Branch.....July 10, 1938.....3 p. m.
Newark.....Sept. 7, 1938.....3 p. m.
Newark.....Oct. 5, 1938.....3 p. m.
Newark.....Nov. 2, 1938.....3 p. m.
Newark.....Dec. 7, 1938.....3 p. m.
Newark.....Jan. 4, 1939.....3 p. m.
Newark.....Feb. 1, 1939.....3 p. m.
Newark.....Mar. 1, 1939.....3 p. m.
Newark.....Apr. 5, 1939.....3 p. m.
Newark.....May 3, 1939.....3 p. m.

*Deceased.

Public Relations

JOSEPH HENRY KLER, *Chairman*New Brunswick
JOSEPH BERKELEY GORDON, *Vice-Chairman*Marlboro
GEORGE BARTON BARLOWEnglewood
EDGAR PARMELE CARDWELLNewark
HOMER ISAAC SILVERSVentnor
JACOB ALLEN YAGERPaterson
ELIAS JOSEPH MARSH, *Consultant*Paterson

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Publication

HENRY C. BARKHORN, *Chairman* (1939)Newark
EDWARD J. ILL (1940)Newark
JAMES LAWRENCE EVANS (1941)North Bergen
WILLIAM JOHN CARRINGTON, *Ex-Officio*Atlantic City
ALFRED STAHL, *Ex-Officio*Newark
FRANK OVERTON, *Editor*Trenton

Meetings

Trenton.....June 5, 1938.....11 a. m.
Newark.....July 27, 1938.....4:30 p. m.
Newark.....Aug. 31, 1938.....4:30 p. m.
Newark.....Sept. 28, 1938.....4:30 p. m.
Newark.....Oct. 26, 1938.....4:30 p. m.
Newark.....Nov. 23, 1938.....4:30 p. m.
Newark.....Dec. 28, 1938.....4:30 p. m.
Newark.....Jan. 25, 1939.....4:30 p. m.
Newark.....Feb. 22, 1939.....4:30 p. m.
Newark.....Mar. 29, 1939.....4:30 p. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Exhibits

ASHER YAGUDA, *Chairman*Newark
JAMES GORDON BOYES, *Vice-Chairman*Plainfield
NICHOLAS MARK ALTERJersey City
WILLIAM WOLF HERSOHNAtlantic City
LUTHER AGUSTUS MARKLEYTeaneck
HARRY ROSS NORTH, *Consultant*Trenton

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Scientific Program

CLARENCE LADELLE ANDREWS, *Chairman*Atlantic City
ROBERT SPEER GAMON, *Vice-Chairman*Camden
LOUIS CHARLES LANGEWeehawken
HARRISON STANFORD MARTLANDNewark
PAUL BRYSON REISINGERTrenton
WILLIAM JOHN CARRINGTON, *Consultant*Atlantic City

Meetings

Trenton.....Aug. 7, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Study of Sterilization

CHARLES WRIGHT MACMILLAN, *Chairman*Passaic
SAMUEL EMLIN STOKES, *Vice-Chairman*Moorestown
WALTER JOHN FARRTeaneck
THEODORE RUSSELL ROBIEEast Orange
*ALFRED FREDERICK SFERRABound Brook
SAMUEL ALEXANDER, *Consultant*Park Ridge

Meetings

Trenton.....June 5, 1938.....11 a. m.
Trenton.....Oct. 2, 1938.....11 a. m.
Trenton.....Dec. 4, 1938.....11 a. m.
Trenton.....Feb. 19, 1939.....11 a. m.
Trenton.....Apr. 16, 1939.....11 a. m.

Traffic Accidents

ELBERT STETSON SHERMAN, *Chairman* Newark
MILLARD FREEMAN SEWALL, *Vice-Chairman* Bridgeton
THOMAS SIMON PADDOCK FITCH Plainfield
CHRISTIAN PETER SEGARD Leonia
GEORGE JOHN YOUNG Morristown
JESSE LYNN MAHAFFEY Haddonfield
WATSON BUDLONG MORRIS, *Consultant* Springfield
ARNOLD VEY, *Technical Adviser*, representing A. W. Magee, Commissioner of Motor Vehicles of N. J. Trenton

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Tuberculosis

ABRAHAM EZRA JAFFIN, *Chairman* Jersey City
SAMUEL BUDD ENGLISH, *Vice-Chairman* Glen Gardner
NORMAN WYVELL BURRITT Summit
LEO BERTHIER DRAKE Franklin
CLYDE M. FISH Pleasantville
MARCUS WARD NEWCOMB Browns Mills
HAROLD SIMON HATCH Morristown
JOHN EDMUNDS RUNNELLS Scotch Plains
HARRY BURTON WALKER Vineland
FREDERIC JAMES QUIGLEY, *Consultant* Union City

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Venereal Disease Control

CHARLES BYRON BLAISDELL, *Chairman* Long Branch
MARSHALL DAVIS HOGAN Boonton
BAXTER ALFONSO LIVNGOOD Swedesboro
STANLEY MARTIN MCGEEHAN Atlantic City
ROBERT RAYMOND SELLERS Newark
STANLEY R. WOODRUFF Jersey City
WILLIAM FRANCIS COSTELLO, *Consultant* Dover
ARTHUR JAY CASSELMAN, *Technical Adviser*, representing Dr. Jesse Lynn Mahaffey, Director of N. J. Dept. of Health Camden

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Voluntary Health Insurance

ELTON WALLACE LANCE, *Chairman* Rahway
EDWARD W. SPRAGUE Newark
JAMES F. NORTON Jersey City
FRANCIS HARRISON TODD Paterson
WILLIAM G. HERRMAN Asbury Park
J. ALLEN YAGER Paterson
LESLIE EDWIN MYATT Bridgeton
NORMAN NES FORNEY Milltown
AUGUSTUS S. KNIGHT Far Hills
HALVOR L. HARLEY Atlantic City
MAX L. WEIMANN Haddon Heights

Welfare

HILTON SHREVE READ, *Chairman* Ventnor
WILLIAM JOHN CARRINGTON, *Ex-Officio* Atlantic City
ALFRED STAHL, *Ex-Officio* Newark
DAVID BACHARACH ALLMAN Atlantic City
FRANK WILLIAM ASH Paterson
GEORGE BARTON BARLOW Englewood
FRANK A. BIEN Irvington
ARTHUR WALTER BINGHAM East Orange
CHARLES BYRON BLAISDELL Long Branch
WENDALL JONES BURKETT Pitman
NORMAN WYVELL BURRITT Summit
EDGAR PARMELE CARDWELL Newark
HARRY NOAH COMANDO Newark
MARCUS ALBERT CURRY Greystone Park
WALTER JOHN FARR Teaneck
FRANK L. FIELD Far Hills
GEORGE WASHINGTON FITHIAN Perth Amboy
JACOB IRVING FORT Newark
BARCLAY STOKES FUHRMANN Flemington
GEORGE B. GERMAN Camden

JOSEPH BERKELEY GORDON Marlboro
DAVID WRIGHT GREEN Salem
DANIEL LEO HAGGETT Trenton
DONALD OSBORN HAMBLIN Bound Brook
HENRY HAYWOOD New Brunswick
EUGENE GARFIELD HERBENER Lakewood
WILLIAM GETTIER HERRMAN Asbury Park
ERNEST GARFIELD HUMMEL Camden
ALLEN GILBERT IRELAND Trenton
ABRAHAM EZRA JAFFIN Jersey City
SIGURD WALTER JOHNSON Passaic
ROBERT ANTHONY KILDUFFE Atlantic City
JOSEPH HENRY KLER New Brunswick
*ISAAC WARNER KNIGHT Pitman
FREDERIC WILLIAM LATHROP Plainfield
JULIUS LEVY Newark
CHARLES LITWIN Teaneck
JOSEPH FRANCIS LONDRIGAN Hoboken
CHARLES WRIGHT MACMILLAN Passaic
JACOB JOHN MANN Perth Amboy
WILLIAM WALLACE MAVER Jersey City
CHARLES HENRY MITCHELL Trenton
BARCLAY WELLINGTON MOFFAT Red Bank
HERSCHEL STRATTON MURPHY Roselle
LESLIE EDWIN MYATT Bridgeton
STANLEY HETFIELD NICHOLS Long Branch
JAMES FRANCIS NORTON Jersey City
BERTHOLD STEINBACH POLLAK Secaucus
WARREN DAVID ROBBINS Cape May
MILLARD FREEMAN SEWALL Bridgeton
TRAUGOTT JOHN SCHUCK Hoboken
REUBEN LORE SHARP Camden
BYRON GRANT SHERMAN Morristown
HOMER ISAAC SILVERS Ventnor
SPENCER TREADWELL SNEDECOR Hackensack
JAMES HERBERT SPENCER, JR. Franklin
SAMUEL EMLEN STOKES Moorestown
*THEODOR TEIMER Newark
ADOLPH TOWBIN Lakewood
CHESTER ISAAC ULMER Gibbstown
HERBERT ROY VAN NESS Newark
WILLIAM HENRY VARNEY Washington
HARRY BURTON WALKER Vineland
WILLIAM CRANE WILENTZ Perth Amboy
JACOB ALLEN YAGER Paterson
GEORGE JOHN YOUNG Morristown
ANTHONY CHARLES ZEHNDER Newark

Meetings

Trenton.....June 5, 1938.....1 p.m.
Trenton.....Oct. 2, 1938.....1 p.m.
Trenton.....Dec. 4, 1938.....1 p.m.
Trenton.....Feb. 19, 1939.....1 p.m.
Trenton.....Apr. 16, 1939.....1 p.m.

Woman's Auxiliary

GUSTAV AUGUST BRAUN, *Chairman* Newark
WILLIAM KING CAMPBELL, *Vice-Chairman* Long Branch
LOUIS FEINSTEIN Atlantic City
GERALD ELLSWORTH McDONNEL Mt. Holly
JOSEPH ROWLETT MORROW Ridgewood
ALDRICH CLEMENTS CROWE, *Consultant* Ocean City

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

Workmen's Compensation

HARRY NOAH COMANDO, *Chairman* Newark
JOSEPH FRANCIS LONDRIGAN, *Vice-Chairman* Hoboken
WILLIAM KLIPSTEIN HARRYMAN Hackensack
V. EARL JOHNSON Atlantic City
HENRY HOWARD KESSLER Newark
CEDRIC C. CARPENTER Summit
FREDERICK WILLIAM SHAFER Camden
DANIEL F. FEATHERSTON Asbury Park
ANDREW FRANCIS MCBRIDE, *Consultant* Paterson
STEPHEN J. LORENZ, *Technical Adviser*, representing J. J. Toohey, N. J. Dept. of Labor Trenton
ROY GRIFFITH, *Technical Adviser*, representing the Manufacturers' Association of N. J. Glen Ridge

Meetings

Trenton.....June 5, 1938.....11 a.m.
Trenton.....Oct. 2, 1938.....11 a.m.
Trenton.....Dec. 4, 1938.....11 a.m.
Trenton.....Feb. 19, 1939.....11 a.m.
Trenton.....Apr. 16, 1939.....11 a.m.

HERRMAN, WILLIAM GETTIER, representing the M. S. of N. J. on the Board of Trustees of the Hospital Service Plan of N. J.
* Deceased.

WOMAN'S AUXILIARY

President, Mrs. DON A. EPLER, 45 Hillside Avenue, Newark, N. J.; Tel. Bigelow 3-7231

President-Elect, Mrs. G. E. McDONNELLMt. Holly
First Vice-President, Mrs. A. E. JAFFINJersey City
Second Vice-President, Mrs. E. R. MULFORDBurlington
Recording Secretary, Mrs. BANKS S. BAKERCamden
Treasurer, Mrs. T. P. CONAGHYCamden

PRESIDENTS, SECRETARIES AND REPORTERS OF COUNTY SOCIETIES

County	President	Secretary	Reporter
ATLANTIC	James H. Mason, Atlantic City...	J. Carlisle Brown, Atlantic City.. Tel. 5-4979	E. H. Nickman, Atlantic City
BERGEN	Chester A. King, Oradell	G. Barton Barlow, Englewood Tel. Englewood 3-7121	LeRoy W. Black, Rutherford
BURLINGTON..	Charles A. Munro, Marlton	E. Warren Rodman, Beverly	Paul R. Sparks, Burlington
CAMDEN	H. Wesley Jack, Camden	George B. German, Camden	Harold D. Barnshaw, Camden
CAPE MAY	Aldrich C. Crowe, Ocean City ...	Clarence W. Way, Sea Isle City.. Tel. 55	Clarence W. Way, Sea Isle City
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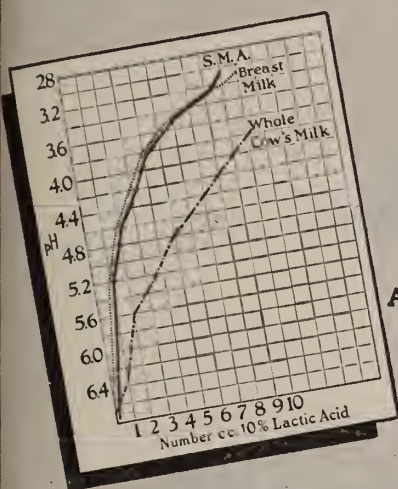
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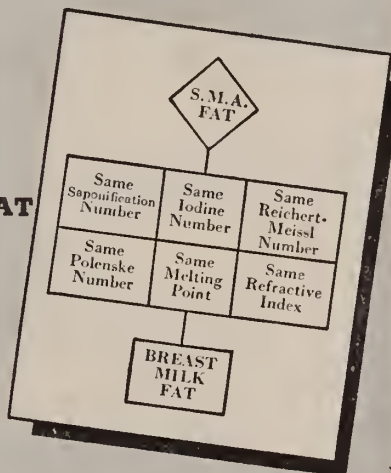
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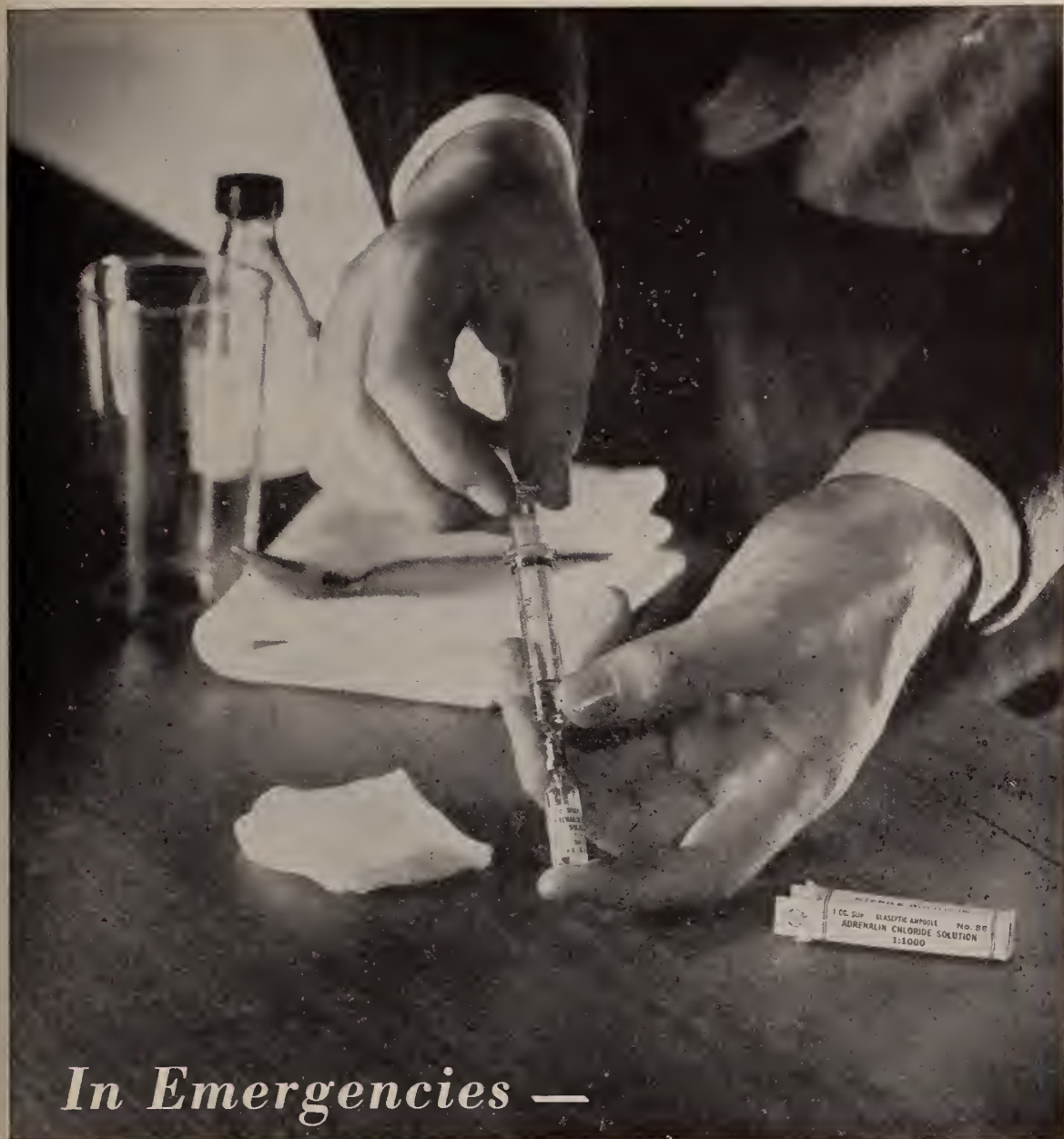
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N. Y. State Jour. Med. 1935, 35-No. 11,590 ☐

Laryngoscope, 1935, XLV, 149-154 ☐

Laryngoscope, 1937, XLVII, 58-60 ☐

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A MESSAGE TO HOME CANNERS FROM THE CANNING INDUSTRY

● Every year, in various regions of the country, a considerable amount of the produce from thousands of small orchards and gardens is preserved for future use by canning in the home. Despite much that has been written on the subject (1), outbreaks of botulism from improperly heat processed home-canned foods continue to be reported.

To eliminate the possibility of botulism from their products—specifically those foods of the “non-acid” type—home canners should take a page from the experience of commercial canners. Through considerable research, the American canning industry has scientifically established the necessary processing requirements for products of this character. For non-acid foods, modern canners employ only recommended process time and temperature schedules (2) known to be adequate to destroy the heat-resistant spores of *clostridium botulinum* whose growth produces the toxin which causes the deadly type of food intoxication known as botulism.

Brief comment on the heat-processing requirements of common foods might be in order. In general, foods or food products may be classed into two groups according to their acidity, i.e., the “acid” and “non-acid” classes with pH values below and above 4.5, respectively. The acid foods include tomatoes and the common fruits. These foods are not favorable to the growth of *clostridium botulinum* and consequently they may be safely processed at 212°F., or the temperature of boiling water.

The non-acid products, however, present a special processing problem. Such products

—meat, fish, fowl, milk and most common vegetables—can be adequately processed only at temperatures above 212°F. As the records indicate (1) botulism in home canned foods may result from processing non-acid foods in boiling water. Safe canning of these foods in the home, therefore, requires the use of properly operated “pressure cookers”—identical in principle with the “retorts” used by commercial canners—which will permit the use of a process under steam pressure. Usually 10 lbs. steam pressure is used in these cookers which corresponds to a processing temperature of 240°F.

Home canners desiring to pack non-acid products should obtain a copy of United States Department of Agriculture Farmers Bulletin No. 1762. In this bulletin are described the necessary equipment, precautions, and time and temperature processing schedules required for the safe canning of non-acid foods in the home. If the necessary equipment cannot be obtained and the recommendations contained in the above bulletin cannot be faithfully followed, some means of preservation of non-acid products other than canning should be sought.

In the interests of public health, it is our sincere hope that home canners may soon become educated to the necessity of steam pressure processes for non-acid foods. Experience dictates that only by processes of this type, with a time and temperature schedule suitable for each particular product, can botulism from non-acid home canned foods be effectively controlled and ultimately eradicated.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

- | | |
|-------------------------------------|--|
| 1. 1934. J. Home Econ. 26, 365-376. | 2. 1937. National Canners Association, |
| 1935. Amer. J. Pub. 25, 301-313. | Washington, D. C. |
| 1935. J. Amer. Med. Assn. 105, 205. | Bulletin 26-L, 3rd Ed. |
| 1936. Food Research 1, 171-198. | |

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-eighth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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Gelatinized Milk DECREASES INCIDENCE OF UPPER RESPIRATORY INFECTIONS IN INFANTS



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Two years ago a group of university workers fed milk containing 1 and 2% plain, unflavored gelatine to a group of infants. There was a lower incidence of vomiting, diarrhea, and constipation than in control groups. As a corollary, they noticed that those receiving the gelatine formula suffered fewer upper respiratory infections. This was interesting enough to demand further study. The work* was recently repeated in two different clinics and the results substantiated. Knox Gelatine (U.S.P.) was used. It is 100% pure U.S.P. Gelatine—85% protein—in an easily digestible form—contains no sugar and should not be confused with factory-flavored, sugar-laden dessert powders.

*Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk. C. Loring Joslin, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

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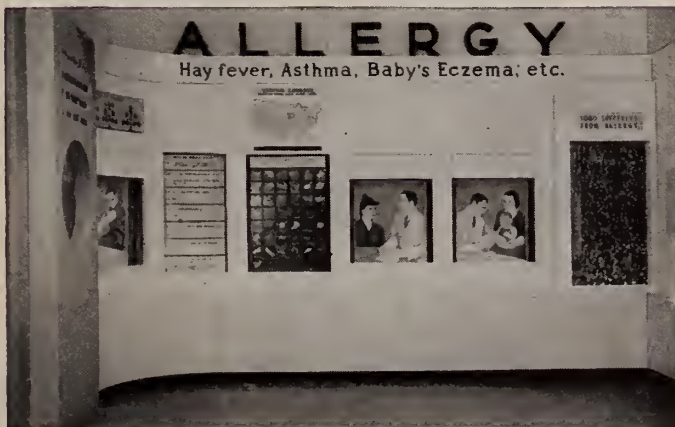
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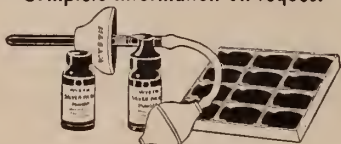
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Is Not Confined to Winter

RAPID CHANGES in temperature, the wearing of light apparel, and the recent innovation of artificial weather conditions in theaters, trains and office buildings appear to increase the incidence of nasal congestion in the summer months.

The so-called "summer catarrh," as well as rose fever, hay fever, and other conditions accompanied by a "running nose" and mouth breathing demand relief just as much as the head colds of winter.

Since so many of these nasal congestive disorders extend over a period of weeks or months, it is gratifying to know that the physician has at his command a vasoconstrictive agent which is active on repeated application, is both prompt and prolonged in action, and seldom displays undesirable side reactions.

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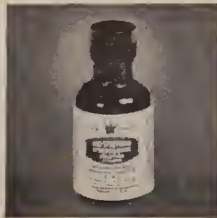
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PUBLISHED MONTHLY

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FRANK OVERTON, M.D., Dr. P.H.

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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. XXXVI, No. 6

JUNE, 1939

Subscriptions, \$3.00 per Year
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EDITORIAL

The Reports of Presidents of County Societies

The date of issuing the May Journal was unavoidably delayed three days in order to edit, proof read, and print the annual reports of the officers and committees, and the Presidents of the county societies.

Printing the reports of the Presidents was authorized by the House of Delegates on May 19, 1938. (Transactions, pages 51 and 53.) But some Presidents were in doubt as to what the scope of their reports should be. However, the reports which were submitted have set a standard and a precedent which all the Presidents may follow next year.

In making their reports the principal difficulty which the Presidents seem to have met was that of choosing the items which directly reflect the coöperation of the County Societies with the State Society. According to the State Society's charter, which has been in effect since 1818, the State Society is composed of delegates from the county societies, thereby establishing the essential importance of each county society in originating, as well as conducting the State Society activities.

An incomprehensible irritation is often shown by officers of county societies over the

number of communications which they receive from the Executive Offices. Even authors of scientific papers have sometimes failed to return proofs of their articles, and have given the explanation that they supposed that the letter was "Just another one from the State Society". This has occurred, although the proofs are always sent in envelopes plainly marked "Office of the Editor". When members fail to answer letters in which they are personally interested, it is no wonder that they overlook other communications.

Each President of a county society is an officer of the State Society in fact if not in name; and he exercises a dominant influence over medical activities beyond the boundaries of his local society. It was therefore a progressive movement when he was given the opportunity to express his opinion regarding the details of the coöperation of his society with the State Society, and to suggest measures for improving that coöperation.

The number and the high quality of the reports of the Presidents that were published in the May Journal justifies the expectation that the plan will be repeated next year.

Development of a New Movement

Every progressive movement in the distribution of medical services follows a definite order of development:

1. A recognition of a real need over a large area.
2. A general unrest among the rank and file of physicians, and a feeling that "Something should be done about it".
3. Numberless corrective proposals made by individual physicians on the one hand; and on the other by welfare groups of laymen supported by endowments and gifts, or by public funds.
4. A serious study of the situation by medical societies through their leaders who give unselfish service on committees. This fourth stage of action is similar to that of a consultation over a difficult case in private practice.

The Medical Society of New Jersey and its component county societies are now in the midst of this fourth stage of action; and their members realize that the patient—the public—is demanding that a new line of treatment shall be instituted. For self-defense, if for no other reason, physicians are under the necessity of developing a comprehensive system of distributing their services by organized measures,—broad and unselfish,—founded on their own experiences.

During the last half-decade, there has been a welling tide of progress in organized efforts of the medical profession to meet the changing conditions of practice. These efforts have been in direct contrast to those of theoretical propagandists in setting up mighty storm waves of so-called progress which recede leaving destruction in their wake.

The spontaneous development of new forms of service sponsored by the medical profession of New Jersey during the last five years has demonstrated that physicians are capable of dealing effectively with the complicated problem of distributing medical services equitably and efficiently. Five years ago the Committee on Public Health was the only one that was

directly concerned with the solution of the problem. Now The Medical Society of New Jersey has twenty committees, with two hundred members, working along the same lines, and with a thousand serving on similar committees in the county societies.

The broad principles on which the organized medical profession is acting are the same as those of any other group of individuals. Every organization requires leaders who have the three qualifications of experience, vision, and a gift of expression. While four thousand devoted members serve as privates in the ranks of organized medicine in New Jersey, the plans of a campaign must be formulated by a very few leaders of recognized wisdom and experience. The task of these accepted leaders is to adapt their plans and suggestions to the capacities and inclinations of the rank and file of the members of the professional army.

Every new movement in the distribution of medical services begins as a desirable *objective* to meet a recognized need—as for example, voluntary insurance for medical care of the low-wage group.

Next comes the adoption of a *policy*,—the appointment of a committee to survey the field of the proposed action, and determine whether or not it will be worth while to attempt a solution of the problems.

The next step is the formulation of plans for a specific *project*,—as for example, the establishment of a central organization to operate a system of sickness insurance under the laws of New Jersey. This involves legal questions and possibly the enactment of new laws enabling the proposed system to function.

The work of the Committee on Voluntary Insurance has hitherto consisted of research and education in the elementary principles of the movement. The committee is now considering a definite plan of real *action* in which the interests of both the patients and the physicians will be protected and promoted. The accurate investigations and wise decisions of the leaders are rapidly becoming accepted by physicians as bases of their future practice.

Medical Leadership in Cattaraugus County, N. Y.

From the time of the ancient Greeks there has been a rivalry between the disciples of Esculapius, the God of Medicine, and the followers of Hygeia, his daughter, whose proper duty was that of ministering at the altars of her father's temples.

Esculapius was the wise and austere God who demanded self-denial and sacrifice, and implicit obedience from his worshippers as the price of his healing services. Hygeia, his attractive priestess, smiling and courteous, won the hearts of her votaries by her specious promises and pleasing words, spoken ostensibly in the name of the God.

In these modern days many votaries of the priestess Hygeia still presume to usurp the place of Esculapius, and to speak as though they themselves possess the God-like art of discerning the mysterious causes of diseases of both the body and the mind, and of exorcising the demons of ill-health. The present great problem in the practice of medicine is whether or not the disciples and successors of Esculapius shall yield their leadership to the votaries of Hygeia, aided and abetted by the Federal Government.

EIGHT PRINCIPLES

Cattaraugus County in Western New York was the arena of an epic contest between the two groups in 1928, as recorded in the pages of the New York State Journal of Medicine of that year.

The immediate occasion of the dispute was the establishment of a county department of health, supported financially by the Milbank Foundation of New York City. The department was designed to be a "Demonstration" of what could be done by a county health department that had sufficient money to hire a staff of "Experts". But the promoters made two fundamental mistakes:

1. Failure to approach the county medical society and secure the support of the practicing physicians.

2. Importing experts to direct the health services, rather than training the local health officers and physicians for the positions. The

impression of observers was that nurses and welfare workers were giving services which were in medical fields.

The Cattaraugus County Medical Society appealed to the Medical Society of the State of New York, whose Public Health Committee held three conferences with representatives of the county medical society and the representatives of the Milbank Foundation. After much acrimonious debate, the conferees agreed upon eight fundamental principles of coöperation and coördination of the several parties engaged in local public health work. These principles were recorded in the New York State Journal of Medicine of May 1, 1928, page 495, and were approved by the House of Delegates of the State Society on May 21, 1928 (Journal, Medical Society of New York, July 1, 1928).

The principles were as follows:

1. It is essential that both official and unofficial health and welfare organizations should recognize the essential importance of the local practicing physicians in carrying on their health projects.
2. Preventive medicine is the doctor's rightful field; and laymen must look to medical men for guidance and leadership in its practice.
3. Public health work within a county involves the coöperation of three groups:
 - a. Lay organizations.
 - b. Official government agencies.
 - c. Members of the county medical profession.
4. The installation of a county health program should be the evolution of the medical forces within the county.
5. The function of lay organizations and employees of the county health department, acting under the leadership of the practicing physicians of the county, includes the following activities:
 - a. Assistance in educational work among physicians and the public.
 - b. Helping those who are unable to carry out the doctor's advice.
 - c. Providing the means for carrying out the public health program that is adopted through the coöperation of all the working groups.
6. Lay organizations are needed for educational work in influencing public opinion regarding legislation and laws, and the procedures of governmental agencies. But the practice of preventive medicine must be controlled and guided by the medical men of the county.
7. The function of the county health officer is not to exercise the duties of the physicians of the county; but to explain the local medical facilities, and to stimulate the people to make use of them.

8. Before any innovation is put into effect by a "Demonstration" or other agency, it should first be studied and discussed by the county medical society, and the professional membership of the county Board of Health.

The result of the conferences was the amicable adjustment of the differences among all the groups engaged in public health work in Cattaraugus County, and the gradual evolution of an efficient County Health Department.

The Medical Society of New Jersey averted a similar conflict with the Federal Government by its offer to coöperate with the State Department of Health in administering the Federal

Funds allocated to the State. Under the system, all the health groups of the State are co-operating efficiently and amicably in maternal welfare, child hygiene, venereal disease control, tuberculosis, and the care of crippled children. The Medical Society of New Jersey is now engaged in formulating and developing a system of insuring the medical care of all persons in the low-wage group.

In New Jersey the High Priests of Esculapius are delivering their oracles in a popular language which the votaries of Hygeia can correctly interpret to the people.

The Annual Meeting

Preparations for the Annual Meeting of The Medical Society of New Jersey, which will open on June 6, are more practical and complete than ever before, and the meeting will therefore have an unusual appeal to the members.

THE HOUSE OF DELEGATES

The proceedings of the annual meeting center in the House of Delegates whose business is conducted in two phases:

1. Reporting and recording the events of the past year.
2. Making plans for the further evolution and extension of the activities during the coming year.

The monthly issues of The Journal have reflected the items of progress which are reported by the officers and committees, as they developed month by month. But the annual reports, which filled seventy-five pages of the May Journal, were summaries of progress throughout the year. While the reports crowded out the editorial department, they were in themselves editorials of special value because they were concise epitomes of the current activities of all departments of the Society.

While it will be physically impossible for all of the thousand or more members who will be present at the annual meeting to attend the sessions of the House of Delegates, two hun-

dred who are accredited delegates will represent the twenty-one county societies, and will impart their impressions to their local meetings after they return home.

INSPIRATION

While the accredited Delegates will spend long hours in the serious consideration of medical problems, the eight hundred additional members who will attend the annual meeting will find inspiration and satisfaction in meeting the leaders on friendly terms. The section meetings will be schools of instruction where every member will have the opportunity to learn the latest methods of diagnosis and treatment. But probably the most practical benefit of the meeting will come from sitting in the corridors of the hotel and greeting old acquaintances and making new ones as the throngs pass in review. Also of lasting influence in cementing friendships will be the unreported conferences in the privacy of the members' rooms.

VISITING DELEGATES

Official delegates from the Societies of neighboring States will be present and will be welcome guests of the Society. It will be a rare privilege of our members to meet the visitors socially and to profit by a mutual exchange of opinions with them.

THE OFFICIAL PROGRAM

Every effort is being put forth to make up the official program in a readable form, so that every member may easily discover the event in which he is personally concerned. Haddon Hall is designed for entertaining large conventions;

and with the program as a guide, every member will easily find the events and the exhibits; and the congenial companions whom he seeks.

Make your plans to spend at least a day or two at the annual meeting. Your investment of time and money will return you attractive dividends.

Official Visits of the President's Cabinet

President Carrington in his President's Page expresses his appreciation of the cordial reception which has been accorded to him and the members of his cabinet on their visits to County Medical Societies. Officials visitors impart their messages in two ways:

1. Formal addresses.
2. Intimate friendly conversation with the local officers, committeemen, and members.

Friendly contacts and conversations accomplish far more than addresses and formal letters of appeal which lack the personal touch. The visiting officers are excellent listeners, and the local points of view which they receive are quite as valuable as the messages which they impart. A message has an effect in direct pro-

portion to the receptivity of the individual who is addressed. An officer or other representative of the State Society is expected to explain its projects, but his real influence is felt when he demonstrates his points in personal conversations with groups who show their interest by the questions which they ask. In fact, the scope of the impressions which are made by the visiting officers may be accurately judged by the size and eagerness of the inquiring groups. Judged by this standard, the official visits of the President and his cabinet have been eminently impressive.

Official visits to county societies by the President and his cabinet are now recognized as essential activities.

The Exhibit on Medical History

The present high objectives and standards of accomplishments of The Medical Society of New Jersey are our direct inheritance from its founders and their successors over a period of 173 years. An unusually large proportion of the present members have inherited their abilities and inspiration from a line of gifted ancestry extending back for two centuries. Some present-day members are our leaders because three or four of their forefathers were Presidents of the State Society. The sons of former Presidents and other high officers naturally chose their wives from among the daughters of other medical leaders, thereby doubling the opportunities for the inheritance of desirable traits. Unravelling their genealogies is therefore of practical importance. The laws of inheritance of family characteristics

are immutable, and their importance transcends all pride of ancestry.

The exhibit of medical history at the annual meeting is a recognition of the debt which present-day physicians owe to their forefathers. The early physicians were prominent in nation-wide medical movements. They helped to develop the first national pharmacopeia in 1819, and assisted in founding the American Medical Association in 1847 and 1848. They established a medical school which failed only because of the jealousy of the schools of New York City.

Many of the Presidents and Secretaries of The Medical Society of New Jersey made extensive researches in medical history, and recorded their observations in papers read before their societies. But it is a deplorable fact that after their deaths, the greater part of their

records and collections were destroyed because no concerted efforts were made to preserve them. But many priceless records still remain and may be discovered by patient research.

An exhibit on medical history will be shown by the Woman's Auxiliary in connection with

its exhibit of art work done by physicians. Visit the exhibit and study its items, and when you return home, assist the historical committee of your county society to find and preserve the priceless records that still await discovery and publication.

Scientific Exhibits

The Scientific Exhibits will be among the most interesting and valuable features of the Annual Meeting. They have been arranged by Dr. Asher Yaguda, who has served as chairman of the committee since 1936. The exhibits will fill all the available space. The exhibit of

fresh pathological specimens will be repeated, and the specimens will be explained by an expert pathologist.

Representatives of the exhibitors will be present to explain the models, pictures, and charts.

Voluntary Health Insurance Committee

The principle of *voluntary health insurance* was endorsed by the special meeting of the American Medical Association on September 16, 1938. Immediately after the return of the New Jersey delegates, President Carrington appointed a special committee to study the subject and make recommendations for adapting the plan to the needs of New Jersey. The committee, in its annual report, announced its intention to continue its study and present its conclusions and a definite plan of action in a

supplementary report to the House of Delegates at the annual meeting on June sixth (Jour., May, p. 275).

The committee has investigated the subject deeply from all points of view, and has secured the advice of counsel regarding the form of a medical insurance plan which can function legally in New Jersey. The committee expects to have the details of its plan of action developed in the near future to a stage in which it may be presented to the House of Delegates for discussion and approval.

An Office for Every County Society

It would seem that the time is at hand to contrive some plan by which each county society shall maintain an office with a clerk in attendance. The simplest suggestion that has been received is that a stenographer employed in the office of a lawyer or business man shall be paid a stipend,—ten or twenty dollars a month,—for receiving the mail and telephone messages coming to the president and secre-

tary of the county society, calling them to the attention of the officers, and writing their replies. If each county society, regardless of its size, receives a stipend of ten dollars a month, the cost will be \$2500 a year; but there would be a saving of more than that amount by the lessened burden upon the clerical force of the Executive Offices.

Can anyone suggest a better plan?

ORIGINAL ARTICLES

THE PROBLEM OF THE DRINKING DRIVER

By ROBERT A. KILDUFFE, M.D., F.A.S.C.P.

Director, Laboratories, Atlantic City Hospital

Read before the 17th Annual Convention of The International Association of Police and Fire Surgeons,
Atlantic City, N. J., September 15-17, 1938.

Among the varied problems which may confront the police surgeon, perhaps none is more common than that which demands of him a definite pronouncement, one way or another, in the case of the presumed "drunken driver". Not only may this determination present many difficulties per se but there may be, and frequently are, many technical and medico-legal phases which add greatly to its inherent complexity.

While drunkenness is by no means a new phenomenon, for references to it occur in the oldest records of the human race, exactly what constitutes drunkenness has often been debated; for, as every one knows, the quantity of alcohol which makes one man obviously drunk, may be without perceptible effect upon another. It is of definite importance, therefore, to determine what constitutes alcoholic intoxication in the eyes of the law and also how exact may be the determination of this state.

While there have been many attempts to formulate a legal definition of drunkenness which will be generally satisfactory and generally accepted, it requires no extensive research to appreciate that such a definition remains to be found. On the contrary, there is every indication of confusion.

IDENTIFICATION OF EFFECTS DUE TO ALCOHOL

Among the many factors which tend to increase the inherent difficulty of the problem may be mentioned the obvious fact that even slight amounts of alcohol, far below that associated with the mildest stages of what is commonly accepted as intoxication, may exert a deleterious effect upon the finer physical and psychic functions which are of special import-

ance in coping with traffic, either as a driver or pedestrian. So also may the cumulative effects of fatigue and excitement; and, finally, the sobering effect of an accident may add a further confusing factor.

The physician may be morally certain that the accused was under the influence of alcohol, but confronted on the stand by a smart, if not altogether scrupulous, lawyer thoroughly "crammed" for the occasion, his evidence may be so distorted as to be of little or no assistance to court or jury.

Much may be made, for example, of the amount of alcohol ingested. But the amount of alcohol,—the number or kind of drinks ingested,—is not in itself a factor of decisive importance. It is not the quantity of alcohol *ingested*, but the quantity *absorbed* which is of crucial importance; for it is absorption and not ingestion which determines the alcohol concentration in the blood which produces the symptoms.

DEFINITION OF INTOXICATION

It is true, of course, that no great skill or ability is necessary to recognize the state of intoxication commonly classified as "Drunk and disorderly". Or even, perhaps, to appreciate the stages, first named by Bogen, from Dry and Decent; through Delighted and Devilish; Delinquent and Disgusting; Dizzy and Delirious; Dazed and Dejected; to Dead Drunk. But the presumed drunken driver may be only in the first of these—delighted and devilish—but to what extent may be quite difficult to determine. In other words, he may be under the influence of alcohol without approximating the colloquial stage of being drunk. The question is, not whether an individual has had one

or two drinks, but whether or not as a driver he is or may be a potential menace to others as well as to himself.

Perhaps the best definition of intoxication in this sense is that of the Committee of The British Medical Association: "That the word 'Drunk' should always be taken to mean that the person concerned was so much under the influence of alcohol as to have lost control of his faculties to such an extent as to render him unable to execute safely the occupation in which he was engaged at the material time".

In Ohio, however, a decision of the higher courts is on record that a man cannot be held to be intoxicated unless he has lost control either of his faculties, or of the muscles of locomotion. This is reminiscent of the old, old story of the Irishwoman who maintained that the prone wreck in the gutter could not be drunk because she distinctly saw him move his little finger. It may also bring to mind the classic remark of Mr. Bumble.

New Jersey courts have decided that, in the matter of driving an automobile, the crucial test is "Whether the individual varies in any degree from the normal mental or physical state; * * * and whether this is the result of the consumption of any liquid which causes intoxication".

In New York the diagnosis of intoxication may be made by a lay witness and based entirely upon observed peculiarities of conduct, gait, or expression; while in Pennsylvania the courts have recognized that none of these may be present or observed, and the individual still possess less than his usual normal clearness of intellect.

It is, perhaps, unfortunate that many courts have ruled that the state of being under the influence of alcohol may be recognized without particular training or ability. For while this may be true in the sense of the Ohio definition, it takes no account of two very important factors:

- a. That the avoidance of traffic accidents largely depends upon a combination of an ability to make lightning decisions, normal coordination, and normal reflex response;
- b. That the signs upon which the lay diagnosis of intoxication largely depend may re-

sult from many conditions other than the ingestion of alcohol.

MEDICAL DIAGNOSIS

Any acute febrile disturbance, thyrotoxicosis, or the hypoglycemia of "Insulin shock" may produce the flushed face as well as many local disturbances of the eyes, mouth, and limbs which may simulate those seen in alcoholic intoxication. Nor is the problem presented to the physician simplified by the fact that various conditions affecting the central nervous system, such as intracranial hemorrhage following trauma, skull fractures, cerebrospinal syphilis (paresis or locomotor ataxia), multiple sclerosis, brain tumor, pernicious anemia with spinal cord lesions, Frederick's ataxia, and so on, may all produce symptoms easily confused with those of intoxication.

As in all medical problems, it is the borderline case which presents the greatest difficulties in diagnosis; and it is an injustice in such cases to base a diagnosis of intoxication upon a cursory examination, and one or two signs or symptoms.

It is essential, first of all, to establish definitely as far as can be done by physical examination, the absence of any pathological condition capable of producing signs or symptoms simulating those of intoxication. And also it must be remembered that the presence of such a pathological condition may so increase the susceptibility of an individual to alcohol that he may be under the influence of alcohol, as concerns traffic regulations, even though the amount known to have been consumed would be, under other circumstances, absurdly small.

It is generally recognized that no single sign elicited by the ordinary methods of examination suffices for the diagnosis of intoxication. This can be concluded safely only from the summation of various methods of examination. These are generally divided into two main groups:

1. The discovery of data tending to establish the fact that alcohol has recently been ingested.
2. The determination whether or not the amount taken has disturbed the normal behavior of the accused.

In the first group are: the smell of alcohol on the breath; suffusion of the face and conjunctivae; tachycardia; abnormal conditions of the tongue or lips (such as a dry, furred tongue or salivation); abnormalities of the pupils; the presence of tremors; or an admission of having taken alcohol.

In the second group fall: memory tests, visual tests, speech tests, coördination tests, and writing tests.

Despite the cumulative significance of such tests when properly applied by a skilled and competent observer, and despite the high degree of diagnostic accuracy which they then possess, they may still be in some measure disparged, if not overthrown, by a clever and not too scrupulous attorney. They can never be free from the possibility of dispute, nor from the assertion that no matter what the examination may be, the physician's diagnosis is, after all, purely a *personal opinion*.

TESTS OF THE AMOUNT OF ALCOHOL IN THE BODY

For these reasons numerous investigators have sought ways and means of determining the minimal concentration of alcohol in the body fluids sufficing to produce intoxication in degrees varying from *mild* to *severe*; and also methods whereby such concentrations could be accurately and easily established.

Many investigations have established the validity of the following rule in the case of individuals who were not habitual drinkers and who had not eaten for several hours, namely:

The ingestion of one gram of alcohol by mouth per kilogram of body weight will cause the blood to contain one gram of alcohol per liter (0.1 per cent), one to two and one-half hours later.

It has also been established that, for some time after taking alcohol, the concentration is greater in the saliva and urine than in the blood, an equilibrium being established within two or three hours.

THE EFFECTS OF VARIOUS CONCENTRATIONS

In view of the importance of the *reaction time* of the driver as a factor in the occurrence or avoidance of traffic accidents, the effect of alcohol upon this has been studied with the following results:

0.05 per cent alcohol in the blood slowed the reaction time 7 per cent.

0.08 per cent alcohol in the blood slowed the reaction time 12 per cent.

0.1 per cent alcohol in the blood slowed the reaction time 19 per cent.

These concentrations are all below those required to produce intoxication, and yet could very obviously be of importance as a contributory cause of traffic accidents.

The concentration of alcohol necessary to produce *intoxication* has been studied by numerous investigators.

Gettler and Tiber * studied the alcoholic content of more than 6000 human brains, including those of total abstainers, and occasional, mild, and habitual drinkers. Their results established the following facts:

1. Regardless of habits, the effect produced is proportionate to the alcohol concentration in the brain.

2. The normal alcoholic content of human brain is less than 0.0025 per cent; while that of those who have partaken of alcoholic beverages ranges from 0.005 to 0.6 per cent.

3. With an alcoholic content of less than 0.1 per cent there are no abnormal physiologic effects.

4. When the content lies between 0.1-0.25 per cent, there is some physiologic disturbance but no loss of equilibrium such as is commonly called intoxication.

5. When the content rises above 0.25 per cent, and up to 0.4-0.6 per cent, the individual is obviously intoxicated.

Their observations show clearly that the effect of alcohol is governed, not by the amount consumed, but upon the *concentration in the brain* at a given time.

Various investigations have established that alcohol taken into the body is rapidly absorbed, and passes to all the fluids and tissues of the body in approximately equal amounts; so that within two hours, absorption is complete and the concentration—and hence a measure of the quantity consumed—may be determined by chemical analysis. If such an analysis is made within two to six hours after the ingestion of alcohol, the amount found expressed in per

1. Gettler, A. O., and Tiber, A.: The Alcoholic Content of Human Brain, Arch. Path. & Lab. Med., 3:218, 1927.

cent, multiplied by the body weight, will approximate very closely the amount taken.

It is apparent from these studies that accurate methods are available for determining the concentration of alcohol in the body; and also that, from such determinations, definite proof of the presence or absence of intoxication may be had.

These determinations, which while quite accurate and reliable are not particularly difficult in technic, may be made upon the breath, or the urine, or the blood; and may be interpreted as follows:

1. When the concentration of alcohol is one milligram or less per cubic centimeter, evidence of physiologic disturbance is rare, and never is sufficient to warrant a diagnosis of drunkenness.

2. A concentration of one to two milligrams per centimeter was the borderline in which, however, a diagnosis of intoxication

may be made in 50 per cent of cases, with 80 per cent showing slight evidences of effect.

3. If the concentration was above two milligrams per centimeter, intoxication was the rule.

LEGALITY OF SECURING SPECIMENS

Despite the accuracy and general applicability of these methods, they have not come into widespread use for various reasons, one of which may be the reluctance of the law to cause an individual to incriminate himself unwittingly. It is doubtful if an accused could be forced to submit to the securing of a specimen of blood against his will, or whether the results of an examination of a urine specimen secured by trickery would be accepted over legal objection.

Be that as it may, the increasing measure of accidents caused by the drinking driver must eventually force some definite, accurate and scientific approach to this grave and growing problem.

HEALTH SURVEY OF PATERSON RELIEF CLIENTS IN 1938

By FREDERICK P. LEE, M.D., Health Officer, Paterson, N. J., and
WILLIAM J. GROSFELD, M.D., Clinician, Valley View Sanatorium, Paterson, N. J.

A survey of the home relief group in Paterson, New Jersey, was made primarily as a tuberculosis case-finding project; but it also presented a splendid opportunity to determine the incidence of syphilitic infection.

In Table I, it will be noted that 3636 persons were examined, of whom about 25 per cent were over fifty years old, and approximately 70 per cent were in the age groups 18-50. Of this group 234 were Negroes.

Ages	MALE		FEMALE		Total Whites	Total Colored	Total White and Colored
	White	Colored	White	Colored			
15-20	65	12	119	6	184	18	202
21-30	334	23	427	40	761	63	824
31-40	370	41	421	39	791	80	871
41-50	489	20	407	15	896	35	931
51 or over	523	20	247	18	770	38	808
Totals	1781	116	1621	118	3402	234	3636

TABLE I.

AGE GROUPS

Weights	MALE		FEMALE		Total Whites	Total Colored	Total White and Colored
	White	Colored	White	Colored			
Normal	596	55	392	34	988	89	1077
Underweights:							
11-20 lbs.	285	25	209	9	494	34	528
21-30 lbs.	168	6	124	10	292	16	308
31-40 lbs.	76	1	48	2	124	3	127
41 or over	24	2	18	1	42	3	45
Total Underweights	553	34	399	22	952	56	1008
Overweights:							
11-20 lbs.	157	9	153	15	310	24	334
21-30 lbs.	115	7	139	11	254	18	272
31-40 lbs.	70	5	96	1	166	6	172
41 or over	78	8	245	18	323	26	349
Total Overweights	420	29	633	45	1053	74	1127
GRAND TOTALS	1569	118	1424	101	2993	219	3212

TABLE II.

TABLE OF WEIGHTS

As shown in Table II, 3212 persons were weighed, of whom approximately one-third were found to be of normal weight, that is, within ten pounds of a normal average as obtained from the "Overweight and Underweight" booklet issued by the Metropolitan Life Insurance Company. Another third were eleven to fifty pounds underweight; and the remaining third were eleven to fifty pounds overweight. Of the underweights approximately 60 per cent were males, in contrast to the overweights, of whom approximately 60 per cent were females. As far as we have been able to ascertain from the Metropolitan Life Insurance Company Statistical Department, these figures are about what to expect in a normal population group.

Table III is interesting in that it differs considerably from Table II. It shows the weights of persons who have x-ray evidence of tuberculosis regardless of activity. Of 119 persons weighed, it was found that fifty-nine males and thirty-four females, or 78 per cent, were underweight; nine per cent were overweight; and 13 per cent were of normal weight.

The significance of these figures cannot be definitely stated, but we believe it to be the result of a combination of several factors. A person having or having had tuberculosis might be expected to be underweight. In addition,

Pounds	Male	Female	Total
11-20 lbs. underweight ..	16	8	24
21-30 lbs. underweight ..	24	9	33
31-40 lbs. underweight ..	12	1	13
41-50 lbs. underweight ..	6	5	11
Over 50 lbs. underweight ..	1	11	12
Total underweight	59	34	93— 78%
Normal	15	0	15— 13%
11-20 lbs. overweight ...	2	2	4
21-30 lbs. overweight ...	6	0	6
31-40 lbs. overweight ...	0	0	0
41-50 lbs. overweight ...	1	0	1
Over 50 lbs. overweight ..	0	0	0
Total overweight	9	2	11— 9%
GRAND TOTALS	83	36	119—100%

TABLE III.

WEIGHTS OF PATIENTS SHOWING EVIDENCE OF
TUBERCULOSIS

this is a group on relief which receives slightly over twenty-five cents per day for food and other incidentals, exclusive of rent and heat. It would seem to us that his meagre allowance is not only inadequate, but perhaps dangerous to the community at large, since it might reactivate an otherwise inactive case under unfavorable conditions, such as an upper respiratory infection, or any other complicating factor which would further reduce the resistance of that individual.

Pounds	Male	Female	Total
11-20 lbs. underweight..	7	5	12
21-30 lbs. underweight..	5	1	6
31-40 lbs. underweight..	2	0	2
41-50 lbs. underweight..	1	0	1
51 lbs. & over underwgt.	0	0	0
Total underweight	15	6	21— 26%
Normal	12	5	17— 20%
11-20 lbs. overweight ...	17	3	20
21-30 lbs. overweight ...	4	3	7
31-40 lbs. overweight ...	3	3	6
41-50 lbs. overweight ...	1	2	3
51 lbs. & over overwgt..	2	6	8
Total overweight	27	17	44— 54%
GRAND TOTALS	54	28	82—100%

TABLE IV.

WEIGHTS OF PATIENTS SHOWING GROSS CARDIAC
ABNORMALITIES

Table IV shows weights of persons with gross cardiac abnormalities as determined only by fluoroscopic examination. We do not consider this table as having any particular significance. Here, among eighty-two persons weighed, we have 26 per cent underweight, 20 per cent normal weight, and 54 per cent overweight. It is possible that this large percentage of overweights may be due to the fact that this group must of necessity have been less active.

The primary purpose of this survey was to determine the figures as set forth in Table V. This table shows persons who have x-ray evidence of tuberculosis. One hundred and thirty-five cases, or 3.7 per cent of the entire group, were found to have tuberculosis, of whom thirteen, or approximately ten per cent, had to be hospitalized immediately, and another thirty-

tuberculous group will have been found to be suffering from active pulmonary tuberculosis.

Another interesting observation is that eighty-eight, or 73 per cent, were minimal; twenty-nine, or 24 per cent, were moderately advanced; and three, or 2.5 per cent, were far advanced, with fifteen cases, or 11 per cent, showing evidence of extra-pulmonary tuberculosis such as Pott's disease for the most part, tuberculosis of the kidney, etc.

When we consider the two age groups in this table we find what appears to be at first glance a very unusual situation,—eighty-four of these persons, or 62 per cent, were forty-six years of age and over. This may not be surprising in view of the fact that in January, 1938, we examined an indigent group of men whose average age was fifty-four, and found not 3.7 per cent as shown in this table, but 15 per cent having evidence of tuberculosis, one-third of whom were in the active stage of the disease and required hospitalization. In this survey the fact that 62 per cent were forty-six years of age and over, does not necessarily mean that these were simply old, healed cases which were not active, for more than half of those already hospitalized, and certainly more than half of those to be hospitalized, are in this group. The fact that approximately 70 per cent were males was to be expected.

Minimal	88	—	73 %
Moderately advanced	29	—	24 %
Far advanced	3	—	2.5 %
Extra pulmonary	15		
	135	—	3.7%

Ages	MINIMAL			MODERATELY ADVANCED			FAR ADVANCED			EXTRA PULMONARY		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-45	12	15	27	10	3	13	1	0	1	4	6	10
46 and over	46	15	61	15	1	16	2	0	2	4	1	5
	58	30	88	25	4	29	3	0	3	8	7	15

TABLE V.

PATIENTS SHOWING EVIDENCE OF TUBERCULOSIS

five persons must be kept under strict observation to determine activity, with the possibility that a goodly percentage of this latter group will have to be hospitalized eventually. This means that approximately 20 per cent of the

Table VI shows persons having evidence of gross cardiac abnormalities as revealed by fluoroscopic examination. It should be pointed out that this does by no means show the actual number of persons in this group having cardiac

Ages	Male	Female
Up to 20	1	0
21-30	3	5
31-40	9	6
41-50	15	9
51-60	25	4
61 and over	14	6
	<hr/> 67	<hr/> 30—Total 97

TABLE VI.

PATIENTS SHOWING EVIDENCE OF GROSS CARDIAC
ABNORMALITIES

disease. It merely means that these ninety-seven persons showed abnormalities such as hypertrophy of the left ventricle, occasionally of the right ventricle, general hypertrophy of the heart as a whole, aneurism, fibrillation, very marked widening of the aortic knob, etc., as could be determined by a fluoroscopic examination.

TABLE VII.

Colored patients showing cardiac pathology..... 8
Extra pulmonary tuberculosis—Potts—colored... 1

Of the 234 Negroes examined, we found no pulmonary tuberculosis present, but did find one case of Pott's disease and eight cases showing evidence of cardiac abnormalities.

Out of a total Negro population in Passaic County of 6000, we examined 615 Negroes,—234 in this survey and 381 in a previous one,—

stage. The mental attitude of the Negro in regard to tuberculosis is such that, when he suspects the possibility of having the disease and that he may be institutionalized, he does not present himself for examination in this type of survey.

Our findings being at such variance with the known facts, it is obvious that any conclusion drawn therefrom would not only be erroneous, but misleading.

Male	38
Female	16
	<hr/> 54

TABLE VIII.

ABNORMAL FINDINGS IN CHEST OTHER THAN
TUBERCULOUS OR CARDIAC

Table VIII gives the number of persons having abnormal findings in the chest other than tuberculosis or cardiac. In this group are included bronchiectasis; foreign bodies such as bullets or knife blades; fibrotic plaques in the pleura; new growths, etc.

Table IX is self-explanatory. There was a total of 218 Negroes tested, sixty-one, or 28 per cent, showing four plus reaction; out of a total of 3126 white people tested, 110, or three and one-half per cent, showed a positive

		Negative	Doubtful	Positive
Colored ... {	Male	77	4	36
	Female	70	6	25
		<hr/> 147	<hr/> 10	<hr/> 61 or 28 %
White {	Male	1535	36	69
	Female	1406	39	41
		<hr/> 2941	<hr/> 75	<hr/> 110 or 3.5%
		<hr/> 3088	<hr/> 85	<hr/> 171 or 5 %

TABLE IX.

WASSERMANN OR KAHN

aged 18-65, and found only two cases of pulmonary tuberculosis and one case of Pott's disease. It appears strange not to find a case rate at least equal to that of the whites, when we know the Negro death rate is four to five times that of the white.

On the other hand, in our regular clinic service we find that 14.4 per cent of Negroes examined showed tuberculosis in an advanced

reaction. The average for the entire group was five per cent. The marked difference in the reaction among the colored and white cannot be taken at its face value because of the very small number of Negroes examined. Since this survey was started, many of the positive reactors have already begun anti-luetic treatment, and we trust that eventually we will bring them all in for treatment.

ABDOMINAL SURGERY IN INFANCY AND CHILDHOOD

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Abdominal surgery in infants and children is a broad subject. The reduction in mortality of the various conditions encountered in this age group depends on early diagnosis and proper operative treatment. I shall endeavor to point out why certain conditions that require surgical interference in these young patients are often diagnosed in a late stage, and why they are often overlooked. In discussing the actual technic of operative treatment, I shall stress only those points that the experience obtained in a large surgical service devoted to the care of infants and children have been shown to be of value.

The better understanding of fluid balance in these small patients is one of the most important factors in reducing operative mortality. Pre-operative and post-operative dehydration can and should in all cases be successfully combated by the administration of adequate amounts of parenteral fluids. Maintenance of body heat, before, during, and after operation is important. Transfusion of blood is now a simple procedure and is of great value in certain cases. There is evidence that a depletion of vitamin C results from vomiting and starvation; and that this deficiency plays a part in delayed and imperfect wound healing.¹ This deficiency can be overcome by the parenteral administration of vitamin C. Gentleness of handling, careful hemostasis, and speed consistent with, but not at the expense of, good technic is essential. These measures are relatively much more important in the treatment of the small patient than of the adult. We must not regard the child merely as an adult on a small scale. Barrington-Ward has summed it up briefly and well by his remark that in surgery: "The adult may safely be treated as a child, but the converse can lead to disaster."

In surgical diseases of the gastro-intestinal tract of children and particularly of infants, vomiting is often a presenting symptom. This vomiting is still far too often regarded as either unimportant, or due to errors in feeding.

Even when it is associated with pain, as in appendicitis, it may be disregarded, or what is worse, a cathartic is given. In infants or young children pain is not always readily noticeable, and the significance of vomiting accompanied by pain may not be appreciated.

Many of us received the impression in the medical school that an infant who vomits is receiving improper food. This, of course, may be the case. But it is very evident that this factor of improper feeding was over-emphasized, and that the impression still remains in the minds of our colleagues. The great majority of cases of pyloric stenosis came to the hospital with the story of repeated changes of formula in the attempt to overcome the persistent vomiting. Vomiting and failure to gain in the absence of infection or acute febrile disease must, in the newborn or in the infant, lead the physician to suspect some *congenital anomaly* of the gastro-intestinal tract which is causing some degree of obstruction.

PYLORIC STENOSIS

Congenital hypertrophic stenosis of the pylorus is one of the commonest conditions of infancy that requires surgical treatment. The symptoms are characteristic and the diagnosis is easy if the condition is borne in mind. In our series of 635 cases, 85 per cent have been in males. The presenting symptom is vomiting, and begins usually about the tenth to the sixteenth day. It is projectile or explosive in character and usually occurs directly after eating. The vomitus does not contain bile. The infant appears hungry and is eager for food even just after he has vomited. This, plus the fact that he has no fever or signs of infection, should at once suggest some mechanical obstructive lesion. The other symptoms are the result of starvation and fluid loss; there is loss of weight; dehydration; and scanty stools, usually termed *constipation*. The stools are composed of intestinal secretion with little of the food elements.

On physical examination, especially if there is much loss of weight, waves of gastric peristalsis are seen moving from left to right in the epigastrium. The upper abdomen is full, and the lower abdomen is sunken. A tumor can be felt in the right upper quadrant under the liver edge. The best time to feel this tumor is immediately after the child has vomited. The tumor feels firm and almost cartilaginous. While generally referred to as olive-shaped, it really is more spool-shaped. If actually felt, there is usually no doubt in the mind of the examiner that it is the pyloric tumor, and not the lower pole of the kidney, or the edge of the liver, or the rectus muscle. We feel that it is possible to palpate the tumor in all cases if the examiner is patient, and examines at a suitable time.

The x-ray after giving an opaque meal is used less and less frequently in our clinic. In most cases the diagnosis is established without it and the presence of barium in the stomach makes the convalescence more difficult.

The operation is never to be regarded as an emergency measure. Except for the cases that are recognized early and are in good condition, we spend from 24-72 hours in pre-operative treatment. Adequate amounts of glucose intravenously and salt solution under the skin must be used. Transfusion is less often needed than formerly, though there are many cases when this measure is indicated. The use of local anesthesia has been discarded in our clinic. Local anesthesia, no matter how well given, prolongs the operation, and adds greatly to the shock because it can never be sufficiently complete to prevent straining. We have used open drop ether in over 90 per cent of our 635 cases and regard it as the anesthesia of choice. Although these patients have a partial obstruction, the combating of the effects of fluid loss, alkalosis and ketosis resulting from this obstruction is the immediate and urgent procedure rather than the relief of the obstruction.

There are a few points to emphasize in the operation itself. The skin incision should be over the middle of the upper part of the right rectus muscle. Its mid-point should be at the level of the liver edge. The liver edge is the important landmark,—not the costal border.

After delivering the pylorus it should be rotated outward and downward, exposing the anti-mesenteric surface, which is comparatively bloodless. The split in the circular pyloric muscle fibers is made here. All fibers must be cut across, and the wound spread with blunt dissection until the mucous membrane pouts out level with the serous coat.

Great care must be taken at the lower or duodenal end of the pyloric incision. Here the transition between the hypertrophied fibers of the pylorus and the paper thin wall of the duodenum is very abrupt. It is here that the surgeon is most likely to make a perforation in the mucous membrane. If a perforation is made, it should be closed with a purse-string suture of fine silk.

Hemorrhage from the incision can usually be controlled with hot packs, but if this does not suffice, the bleeding points should be trans-fixed and tied. Attempts to snap and tie are usually unsuccessful as the tissues are friable. Unfavorable results from hemorrhage or peritonitis should be minimal.

FLUID REQUIREMENTS

A more common cause of bad results is failure to meet the fluid requirements of the infant. A good working rule is to see that these patients receive and retain three ounces of fluid per pound every twenty-four hours for the post-operative interval of five to seven days. At first it is neither possible nor desirable to attempt to meet in full the caloric requirements. We begin feedings of water and whey by mouth, giving one ounce at two-hour intervals for the first twenty-four hours. After this breast milk is used and the amount gradually increased and the interval lengthened. We do not attempt to have them on a normal caloric schedule until the fifth or sixth day, but we do take great pains to meet the fluid needs. We believe that pyloromyotomy is the treatment of choice for pyloric stenosis. With proper attention to combating fluid loss before and after operation, with good operative technique, especially as regards hemostasis and careful wound suture, the mortality should be very slight. Surgery offers a safe, prompt, and lasting relief of symptoms. Our total mortality

in 635 cases is 5.2 per cent, and during the past four years there was a period when we operated on 167 consecutive cases without a death.

PYLORO-SPASM

The chief condition to be differentiated from pyloric stenosis is the so-called pyloro-spasm. There is undoubtedly a certain element of spasm associated with a true stenosis, especially if the condition has existed for a long time. True spasm, however, does exist alone, and it can be differentiated from stenosis by its more gradual and later onset, the irregular progression of symptoms, and the failure to demonstrate a tumor.

The hypertonicity of the child, and its response to proper feeding with or without the use of atropine, also help to make the differentiation. Fortunately, the less characteristic and progressive the course of symptoms, the less is the need for haste in considering operation. The infant in such cases does not exhibit as marked a loss of weight and body fluid. We believe that failure to gain on a suitable formula, plus the palpation of the tumor, is a more reliable guide in a differential diagnosis than barium x-ray studies, though these have their place in some doubtful cases.

Projectile vomiting occurring in the first few days of life should always make one consider and rule out intracranial birth injury, though we have observed one case of pyloric stenosis in which the symptoms began on the fourth day of life.

CONGENITAL OBSTRUCTION OF THE DUODENUM

Another rare condition simulating pyloric stenosis is congenital obstruction of the duodenum. This may be *intrinsic* or *extrinsic*.

The *intrinsic* form may have a partial or complete obstruction due to persistence of the epithelial condescence which takes place in the embryo before the lumen of the bowel is re-established. This results in a membrane or diaphragm across the lumen of the duodenum. If this is complete, the symptoms are, of course, those of complete intestinal obstruction, and begin directly after birth. We have had cases, however, in which this obstructing dia-

phragm was not complete, and in these the symptoms closely simulate pyloric stenosis in their character and in the time of their appearance. The differential points are the presence of bile in the vomitus, and the absence of a pyloric tumor. These cases may be treated by duodeno-jejunostomy, and we have seven cases treated successfully by this method. Morton² suggests opening the duodenum and cutting the obstructing membrane and has reported one case successfully treated in this way.

True atresias may exist anywhere in the gastro-intestinal tract. The symptoms are those of complete intestinal obstruction, and vary with the level of the obstruction. In localizing the site of obstruction, the x-ray without a contrast media is often a help.

Normal meconium contains mucus, bile, lanugo hairs, vernix caseosa, and keratinized epithelial cells, all of which are swallowed by mouth with the amniotic fluid during intra-uterine life. Search for keratinized epithelial cells in a smear from the rectum is a simple procedure. The smear is dried with ether, stained with Sterling's gentian violet for one minute, and decolorized with acid alcohol. Failure to find these cells is an indication that there is a complete obstruction, as has been pointed out by Farber.³ This is a quick and reliable guide if one takes care not to scrape off epithelial cells from the skin about the anus in making the smear.

In most cases of atresia, an anastomosis is necessary, and this requires special technic. Because the bowel distal to the atresia has never been dilated with feces, it is usually smaller than it should be, even for the age of the infant. The proximal bowel is usually distended. However hopeless the condition appears, it is worth while to attempt a repair. Enterostomy alone is not well tolerated and usually only postpones the end.

Dilation.—It is our practice to open the distal segment and dilate it with a small catheter through which air or fluid is injected. In order to insure an adequate lumen at the site of the anastomosis, the catheter is left in place until the suture is nearly completed. In these cases it is not practical or possible to use more than one row of Connell suture of fine arterial silk.

It is gratifying to observe how surprisingly well the small rudimentary distal portion of the bowel enlarges if the anastomosis has been successfully performed. The successful cases are those that are diagnosed early. If there is undue delay, the proximal portion of the bowel becomes enormously dilated with thick tenacious meconium. This renders the chance of successful anastomosis slight, and also interferes with the circulation of the proximal loop so that perforation frequently occurs with resulting peritonitis.

EXTRINSIC OBSTRUCTION OF DUODENUM

Extrinsic obstruction of the duodenum occurs. This is dependent on a faulty development of the midgut mesentery, and a failure of the cecum to rotate and descend into the right lower quadrant. This anomaly may result in two conditions:

First, *volvulus* of the midgut which gives characteristic symptoms of small bowel obstruction.

Second, *pressure* on the duodenum where the mesentery of the cecum crosses it.

The cases of duodenal obstruction due to this extrinsic factor have symptoms similar to those due to an intrinsic obstruction. They also are to be differentiated from pyloric stenosis by the absence of a pyloric tumor and the presence of bile in the vomitus.

The surgical treatment consists in mobilizing the cecum, ascending colon, and part of the transverse colon from its attachment to the right of the duodenum and allowing it to reflect back into the left upper quadrant where it was at an earlier period in its embryological development. This should completely expose the duodenum. The *volvulus* of the midgut, if it exists, must be reduced. The *volvulus* usually involves the entire midgut and rotates clockwise on its rudimentary mesenteric stalk. It is also most important in these cases to remedy the defect in the attachment of the mesentery of the cecum as described above. This can be done at the time of the reduction of the *volvulus*, if the patient's condition permits,—otherwise later. We have found that, if this is not done, the *volvulus* will recur. Do not be afraid to have a long incision, and to deliver the whole

bowel into the wound; if the gut is well protected with hot packs there is less shock than in trying to visualize and treat these puzzling anomalies through an inadequate incision. Cases of midgut *volvulus* occurring in infants and children are almost always due to this anomalous attachment of the midgut mesentery, and this anomaly is almost always associated with a non-rotation and non-descent of the cecum. Partial obstruction of the duodenum from pressure of the anomalous attachment of a non-rotated or non-descended cecum may occur later in childhood. This embryological defect must also be considered in cases of a high appendix under the liver.

ANOMALIES OF THE BILE DUCTS

Congenital anomalies of the bile ducts occur, and result in the inability of the bile to reach the duodenum. Such cases present a progressive jaundice, an enlarged liver, no fever, clay-colored stools, and bile in the urine.

The diagnosis is established by exclusion. To be excluded are: *icterus neonatorum*, which clears up rapidly; jaundice due to sepsis, which has other manifestations of sepsis; syphilis, which is excluded by serological tests; and a certain hemolytic condition, *erythroblastosis fetalis*, which occurs in the first few days of life, and progresses rapidly to a fatal outcome unless cured by transfusion.

As has been reported by Ladd,⁴ these cases should be explored. About one-third of our sixty cases have had an anomaly that permitted some form of anastomosis of the extra-hepatic bile ducts with the gastro-intestinal tract and have resulted in a cure. The hopeless cases are those with no extra-hepatic bile ducts.

INTUSSUSCEPTION

This is the outstanding surgical abdominal emergency of infancy and early childhood. There is no other condition in which early recognition and early surgery is of such paramount importance. There are two types: First, the so-called *idiopathic*, in which there is no demonstrable cause for the intussusception. This type has its peak of incidence at the sixth month of life. It is uncommon after two years of age.

The history in typical cases is so characteristic that the diagnosis should never be missed. There is evidence of acute abdominal pain occurring in spasmodic attacks and associated with vomiting, pallor, and other symptoms of shock. Again and again we get the story from the mother that the type of pain is different from any other previous sort of colic, and that the child becomes pale and perspires. Blood and mucus usually appear in the stools several hours after the onset of pain. The reasons why intussusception is overlooked are these: the condition is not kept in mind; the symptoms characteristically occur in well-nourished, healthy babies; they occur with great suddenness, may last only a few minutes, and be followed by a period of complete relief. During the early hours it is extremely difficult to palpate the mass, which is then in the ascending colon, and may be under the liver edge, as practically all cases of this type start at the ileo-cecal valve. Also, the first bowel movement after the onset may contain normal-appearing material from the colon distal to the advancing point. In between attacks the child looks and acts normally, and there is no fever, but rather a subnormal temperature. The oft-spoken-of "Sausage-shaped tumor" does not appear until the advancing point has reached the transverse colon or splenic flexure. Blood and mucus by rectum usually appear early but a strong suspicion of this disease should be aroused by the history of severe spasmodic abdominal pain, often associated with pallor and reflex vomiting, unassociated with fever, and occurring in healthy infants.

The mortality in cases diagnosed in the first 12-24 hours should be negligible. We deplore the attempts to reduce this type of intussusception by hydrostatic pressure. This method is reported as successful in early cases, but it is not a sure method, and in our opinion carries as much shock as a well-done laparotomy. The mortality should be negligible when good surgery is used for cases where reduction by enema is likely to be successful. If enemata are used and are not successful, they add to the delay, and to the shock of the subsequent operation.

The operative incision should in all cases be

right paramedian. While the mass is felt to the left of the midline in late cases, the most difficulty in reducing the intussusception is encountered at the ileo-cecal region. In nearly all cases it is necessary to deliver the cecum in order to complete the reduction. If the advancing point is in the transverse colon, or even in the descending colon, it can usually be reduced intraperitoneally without difficulty. The advancing point must be pushed out—not pulled out. Unless the serosa tears easily, slow, gentle attempts at manual reduction should be persisted in for some time.

Once reduced, a few minutes' observation will tell whether the gut is viable. It is rare for the gut to be non-viable if manual reduction has been accomplished. And it is much safer to rely on the probability that the gut is viable and not to resect in such cases. The old method of making a very small scratch in the serosa with a needle and seeing if it bleeds is a reliable test. It is always a temptation to remove the plum-colored and gangrenous-appearing appendix in cases where the appendix has been drawn into the invaginated gut. This is practically never necessary; and to do it is to court disaster. The discoloration and odema of the appendix is the result of intussusception; and if the appendix is viable, there is no more need to remove it than to resect the discolored but viable bowel. To remove it in the presence of a damaged peritoneum is dangerous in itself, and adds, even though slightly, to the shock of the operative reduction. There is nothing to be gained and much may be lost by appendectomy.

We heartily believe that there should be no attempt made at the time of reduction to prevent a recurrence. The cause of this type of intussusception is unknown, and measures taken to prevent a recurrence, such as fixing the terminal ileum, are ill-founded, ill-advised, and fraught with danger to the patient. The suturing of the bowel is done in the presence of a damaged peritoneum, and, as in appendectomy, this invites disaster. Recurrence is rare—less than three per cent in our series,—and there has been no mortality in our recurrent cases. Indeed, so dramatic is the history of this disease that a recurrent case usually

appears back at the hospital in an amazingly short time after onset.

Irreducible cases require resection. The mortality is extremely high. In recent years it has improved, largely because of the better post-operative care, as well as better operative technique. While in desperate cases resection and the double-barrelled Mikulicz enterostomy is probably the safest procedure, we have had success in better risk patients with primary side-to-side anastomosis following resection. Resection must be done well away from the damaged gut. In practically all cases of any sort where resection is used, the side-to-side method of anastomosis is the one of choice for this age group. It takes little extra time, and an adequate stoma is assured.

There is another type of intussusception that occurs in infancy and childhood. This is the same as that seen in later life. That is, there is a definite mechanical cause for the intussusception, such as an intestinal polyp, or invaginated Meckel's diverticulum. Here the symptoms do not differ from those seen in the adult, though they may be far less dramatic in onset than in idiopathic intussusception.

MECKEL'S DIVERTICULUM

It is apparent that abdominal conditions caused by Meckel's diverticulum were and still are frequently overlooked. This alone will explain the remarkable increase in the incidence of this diagnosis at the Children's Hospital and elsewhere in the past few years.

The symptoms vary. Acute inflammatory conditions of a Meckel's diverticulum cannot be differentiated from an acute appendicitis, and need not be, since both require laparotomy. It is important to emphasize, however, that given the typical history and physical findings of an acute appendicitis, if a normal appendix is found, then the terminal ileum must be exposed and Meckel's diverticulum ruled out. Where this was not done we have had several cases with recurrence of symptoms; and they came to us shortly after a laparotomy, plus removal of a normal appendix. A high percentage of Meckel's diverticula have stomach cells in their mucosal lining. This explains the high incidence of bleeding by intestine, about

60 per cent in our series. It is probable that many cases diagnosed as duodenal or gastric ulcer were really peptic ulcer caused by the gastric mucosa in the Meckel's diverticulum. From our experience, duodenal or gastric ulcer in this age group is extraordinarily rare. Other varieties of symptoms depend on the actual type of the diverticulum. In addition to inflammatory lesions there may be obstruction, volvulus, or intussusception. The attacks may often be subacute in nature, and consist of intermittent colicky attacks of pain of varying intensity, often associated with vomiting, less commonly with fever. The symptoms are often vague, and are attributed to dietary indiscretion. They warrant, however, careful study, and especially an examination of the stools for blood. There may be a large, sudden and alarming hemorrhage from a Meckel's diverticulum. In considering the cause of melena, gross or slight, Meckel's diverticulum should always be borne in mind, especially when no evidence of any blood disorder, such as the purpuras, is found by the study of the blood.

Intestinal polyps, while usually single and usually near the anus, may be multiple and may be anywhere in the large or small bowel. When situated high up, they may cause an intussusception. The presenting symptom, wherever the polyp may be located, is usually *bleeding*. If the melena is accompanied by intermittent colicky abdominal pain, whether or not associated with vomiting, and if it persists in spite of proper dietary habits, a polyp or a Meckel's diverticulum must be carefully considered.

GENITO-URINARY

Among the causes of abdominal pain in childhood pathology in the genito-urinary tract must always be considered. The abdominal symptoms of an intermittent hydronephrosis caused by an aberrant vessel crossing the ureter is a classical example. Intravenous pyelography is an easy and valuable aid in these obscure cases. It is true that many cases with vague and obscure abdominal symptoms have been submitted to unnecessary surgery in the past. Some of these, however, were submitted not to unnecessary surgery, but to incorrect surgery, in that an innocent appendix was re-

moved, and no further search was made for the real cause of the trouble. In such cases one must not be content to merely examine and remove the appendix. More careful study of both the gastro-intestinal and genito-urinary tracts will make for better selection of cases that justify exploration, and will also not allow the case that needs exploration to be treated medically for too long a period.

DUPLICATIONS OF THE ALIMENTARY TRACT

These duplications, as described by Ladd,⁴ may occur at any point in the alimentary tract from mouth to rectum. When in the peritoneal cavity they may give symptoms similar to Meckel's diverticulum with hemorrhage, or those of partial obstruction. A pre-operative diagnosis was suspected in a few of our eighteen cases, but was not made definitely in any. These lesions are often incorrectly called giant diverticula, unusual Meckel's diverticulum, ileum duplex, or mesenteric cysts. It is important to recognize that a true duplication has the same blood supply as the overlying bowel, and usually cannot be removed without resection and anastomosis. They should be removed in all cases.

APPENDICITIS

Appendicitis is, of course, the commonest surgical condition of the abdomen, even in this age group. That it is frequently overlooked is obvious from its high mortality. The figures of the Massachusetts State Department of Public Health show that, in children over one and under ten years of age, deaths from appendicitis rank third, and that they are exceeded only by pneumonia and accidents. It is a preventable cause of death.

There are several reasons why appendicitis is overlooked. It is not thought of, and therefore often receives vigorous catharsis at the onset, commonly by the mother but regrettably often by the physician. Education of the public will do great good here.

There are several reasons why an acute appendicitis may be overlooked at the actual physical examination. The meso-appendix, the meso-cecum, and the appendix itself are relatively longer in the child than in the adult.

The appendix, therefore, is more mobile; and it may be, and often is, away from its normal location in the right iliac fossa. The pelvis of the child is relatively narrower and deeper than in the adult. These anatomical factors explain a common cause for overlooking an acute appendicitis in a child. If the inflamed appendix lies deep in the pelvis, the abdominal symptoms and signs may be minimal. Also there may be diarrhoea or dysuria caused by the inflammation adjacent to the rectal or bladder wall. In cases that have diarrhoea, beware of the diagnosis of "Intestinal grippe". Fortunately, although the abdominal signs and symptoms are less, the deeper the inflamed appendix lies in the pelvis, the easier becomes the detection of its presence by rectal examination. The oft-repeated warning of my late Chief may be quoted here. "The consultant has two functions; the first is to do a rectal examination, and the second is to console the family. If the physician who first sees the patient will usurp the first function of the consultant and do a rectal, there will be less need for a consultant to console the family." A finger cot is a far more useful bit of apparatus in such cases than the microscope and a blood-counting pipette. The appendix may be retro-cecal, or mesial to the cecum, in which cases the tenderness is lessened by the overlying cushion of gas in the cecum.

Always remember that the child cannot localize his symptoms. In the examination of the abdomen, the greatest gentleness must be used, and every effort made to obtain coöperation. Local tenderness and true involuntary muscular spasm are of the greatest significance. But the opportunity to determine these is too often lost by a hasty, rough, and unsympathetic examination.

There are two conditions which are often mistaken for appendicitis. The first is an acute infection of the *kidney*. Here there is fever, vomiting, leucocytosis, and abdominal pain, tenderness, and spasm. The constitutional symptoms from the start are usually much more severe than in an appendix in the first twenty-four hours from its onset. In a kidney lesion, the abdominal tenderness and spasm, though they may be present in the right loin,

are maximal in the costo-vertebral angle. Pus in the urine is usually found, though it may be absent in the first 24-48 hours; but if absent, the constitutional signs are usually great and the costo-vertebral tenderness marked.

A low, right-sided *pneumonia* will give fever, vomiting, leucocytosis, abdominal pain with tenderness, and muscular spasm in the right side of the abdomen. Reliable differential points are these. It may not be possible to detect the early central pneumonia by auscultation and percussion, but the constitutional signs are far greater than in an appendicitis, and note should be taken of the type of breathing, of the slight cyanosis, and the movements of the alae. In pneumonia the abdominal muscles are held in spasm to splint the diaphragm and so lessen the painful breathing caused by the diaphragmatic pleurisy. Gentle, even pressure of the whole examining hand takes the place of these rigid muscles in splinting the diaphragm, and this muscular spasm will relax. If, of course, these muscles are held in spasm to protect an inflamed appendix, no matter how carefully and gently the pressure of the examining hand is increased, the muscles become more spastic. The fluoroscope, if easily available, may often reveal the pneumonic process in these doubtful early cases. The leucocytosis and fever are usually much higher in these two conditions than in an acute appendicitis. A temperature over 102° in an early stage should cause one to carefully consider some condition other than appendicitis.

The much-maligned chronic appendix, or better, the recurrent mildly inflamed appendix, does exist. More cases deserve exploration with removal of the appendix, plus a search for other possible sources of trouble, than perhaps the lay person or even the medical man would agree. We have a sufficiently large series of cases followed over a long period of time to feel sure that the patient's clinical cure resulted from the removal of a relatively normal-appearing appendix. At operation these cases often have an associated mesenteric adenopathy.

Acute mesenteric adenitis gives symptoms almost identical with acute appendicitis. There is more frequently, however, the history of a

coincident upper respiratory infection. The constitutional signs are usually much greater, and are out of proportion to the abdominal findings. For example, in a patient with a thirty-six-hour story of abdominal pain, vomiting, temperature of 103° , and a white count of 20,000, one would expect to find marked tenderness and true involuntary spasm by the abdominal examination. In an acute mesenteric adenitis there is likely to be local tenderness, and perhaps some spasm, but not enough to account for the general symptoms, the severity of which would suggest perforation and peritonitis if due to appendicitis. In doubtful cases, however, it is probably safer to operate than to wait.

Acute fulminating peritonitis due to the streptococcus or pneumococcus usually have some preceding lesion elsewhere. The mortality is high with both late and early operation. It is probably better to regard these cases as suffering from a septicemia with local involvement of the peritoneum, and to treat the child as a whole by supportive measures, certainly during the stage of severe initial toxemia. This problem is not unlike that of acute fulminating osteomyelitis, where, in our age group we have reduced our mortality greatly by withholding radical surgery during the acute and early stage of toxemia.

I would especially emphasize the need of recognizing these cases, if not before operation, then certainly on opening the abdomen. The pus in pneumococcus or streptococcus peritonitis can usually be recognized, especially important being the presence of fibrin and the absence of colon bacillus odor. When the surgeon encounters these types, he must not look for disease in the appendix or other organs. Any handling or exploration reduces the chance of recovery. A culture should be taken, and a drain or drains be inserted, and the small exploratory incision closed.

If the streptococcus is grown on culture, sulphanilamide should be given; if a type of pneumococcus for which there is a serum, that serum should be used. The final answer as to the value of these forms of therapy cannot yet be given, though we appear to have had some favorable results.

Diagnostic abdominal puncture for culture of the fluid is dangerous. It is never possible to be sure that the gut will not be entered, and we feel this procedure should be condemned. A small exploratory opening made under direct vision, using avertin and novacaine, is far safer.

When to operate in acute appendicitis with peritonitis is a much debated question. In the profoundly toxic case with diffuse generalized peritonitis, delay is advisable, and general supportive measures should be used.

In general, however, we believe that cases of ruptured appendix even with peritonitis should be operated on and drained without delay. Each case must be decided on its own merits, and the more careful the consideration and the better the operative technic and post-operative care given each case, the better will be the result.

The cases from our clinic are being studied by Hudson, who will report them later. No case is considered in the series unless proven as acute appendicitis. So far he has analyzed 504 cases, of which 54 per cent were drained. The total mortality for the group is 3.9 per cent, which compares very favorably with that of other authors.

It is sad commentary on the social and economic situation of the country that, in times like these, the percentage of cases of appendicitis admitted with a diagnosis of ruptured appendix is higher than in more prosperous years. The obvious explanation is that they are treated at home, and the physician is not called until late. The remedy for this is not for me to suggest here.

We still favor the right rectus muscle incision. In cases where the necessity of drainage is probable, we prefer the muscle splitting incision to the paramedian, or to retracting the muscle inward. The McBurney incision has its place, but in these small patients where the appendix is so often in an abnormal location, this incision should not be stubbornly adhered to. The right rectus incision, if properly done, is in our opinion more useful and safe in this age group.

The post-operative care of a patient with a ruptured appendix should include adequate

amounts of morphia, and parenteral fluids. We advocate putting the duodenal tube in place at operation, rather than waiting for distention to develop. The duodenal tube reduces distention due to paralytic ileus caused by peritonitis. Useful as is this tube, it must be remembered that it may mask the distention that is caused by a mechanical obstruction.

Early enterostomy using a catheter and the Witzel method is to be strongly recommended in these obstructive cases. Placing the patient in an oxygen tent, and using a high percentage of oxygen, 80-90 per cent, seems to be a help in combating distention as has been recently advocated by Fine.⁵ It is now our practice to use this tent, plus the duodenal tube, right from the start in any case of peritonitis or any case of intestinal anastomosis where later distention is to be feared. The results are most encouraging in the small series to date.

Tuberculosis of the abdominal cavity is becoming a rarity but should always be considered, and operation is to be done only in cases of obstruction. If not suspected before operation, it can readily be recognized at operation by the tubercles studded on the bowel. The less surgery done in such cases, the better.

New growth is usually of the kidney; much less often of the pelvic organs, omentum, or bowel itself. Though rare, it must often be considered. Exploration is justifiable and radical removal should be done whenever possible.

THE HISTORY

In summary, let me quote again from my late Chief, Dr. James S. Stone:

"In the diagnosis of abdominal conditions in children there is nothing more important than the history, and oftentimes there is nothing more difficult to obtain than a complete and accurate history. A correct diagnosis cannot be inconsistent with a correct history and physical examination. If they are inconsistent, either one or another must be wrong or incomplete.

"Listen patiently and thoughtfully to the story of the illness, and ask questions which will bring out the whole truth as far as possible. If this is done, many conditions may be practically eliminated before the child is seen. Then

see everything that can be seen, and lastly feel all that can be felt, including what can be felt in the pelvis by rectal examination.

"When the examination is finished, consider the whole picture and the whole history. No undue emphasis is to be placed on any one feature, either of history or of examination, nor is any feature of either to be disregarded.

"Then will come the use of the laboratory aids. The laboratory must be used whenever practicable, but always try to have the laboratory help *confirm* the diagnosis rather than *establish* it."

If all this is carefully done, the diagnosis is

usually plain. Finally, let me state that it is of far greater importance to the patient to recognize the necessity of an exploratory operation than to make an accurate pre-operative diagnosis of the lesion itself.

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MODERN CONCEPTS OF THE ETIOLOGY OF PEPTIC ULCER AND THEIR BEARING ON THERAPY

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Of fundamental importance in the consideration of any disease process is its mode of causation, since exact knowledge concerning its origin is of paramount importance in its prevention, cure, or eradication. Yet in spite of unprecedented scientific progress in the last half century, one is witness to the paradox of incomplete knowledge of the pathogenesis of many common disease entities. A continued interest in problems connected with the etiology of chronic gastroduodenal ulcers is justified by one fact alone, namely, the great prevalence of the disease, directly affecting, as it does, the health and efficiency of many adult members of every community. Moreover, many competent observers are definitely of the opinion that peptic ulcer, and especially duodenal ulcer, is greatly on the increase, both absolutely and relatively.

For years the problem of the origin of ulcer has been studied from the anatomic, pathologic, clinical, and experimental points of view. Because of the achievements of modern research, one wonders why the problem has not already been definitely solved in the experimental laboratory. In the first place, chronic ulcer is a disease peculiar to man. In the second place,

the production of the chronic experimental lesion is only possible after extensive operations on the viscera, producing changes in physiologic functions so profound that it is somewhat difficult to conceive how such changes could occur in the intact human stomach or duodenum. Thirdly, granting that psychologic or neurologic factors are prominent etiologic agents, their experimental verification would prove exceedingly difficult. And, finally, it seems reasonable to presume that the factors giving rise to a chronic visceral lesion in the human stomach cannot be approximated in the acute experiment. Nevertheless I feel that experimental research has supplied valuable information with respect to the development of the chronic lesion consistent with certain clinical and pathologic facts and observations.

As evidence of the many conflicting views regarding the nature and origin of ulcer are the numerous theories which have from time to time been advanced. These theories are inseparably linked with an array of personalities famous in medical history. These pioneers may be looked upon as medical prophets because in many respects we still subscribe to some of their tenets which the passing of time and med-

ical progress have proved to be of merit. Thus before us pass in review these various theories which still challenge and give us pause: the vascular, chemical or corrosive, gastritic, infectious, traumatic, mechanical, incretory, deficiency, allergic, and neurogenic.

Some of these theories had their inception almost a century ago. In 1853 Virchow formulated the concept that ulcer was dependent on vascular disease. Some years previously Rokintansky pointed out the possible significance of hemorrhagic and follicular erosions, and made the original and prophetic statement, according to Cushing, that certain peptic ulcers are caused by "A diseased enervation of the stomach, owing to a morbid condition of the viscus, causing extreme acidification of the gastric juice". As early as 1880, Cohnheim laid the basis for the theory that the formation of ulcer depends on chemical factors, and an abnormal acidity of the gastric juice was considered possible but not proved. Six years later Riegel attached great significance to hyperchlorhydria in the development of chronic ulcer. This conception of focal nutritional changes from whatever cause, and the digestive action of the gastric juice in the pathogenesis of ulcer, has a familiar ring even today.

THE VASCULAR THEORY

This theory, as conceived by Virchow and later championed and amplified by Hauser (1883), while acceptable to the modern pathologists, is not regarded with favor by experimental investigators. What seems more likely is that atherosclerotic processes in the gastric arteries interfere with healing of a gastric ulcer, as was emphasized by Ophüls in 1906; and in the chronic penetrating type of lesions, predispose to severe if not fatal hemorrhage. It is reasonable to believe that gastric ulcers developing in elderly, arteriosclerotic individuals, which ulcers are often mild in their manifestations and often associated with hypochlorhydria or achlorhydria, could be the result of a thrombotic, embolic, or occlusive process in the sclerotic vessels. The participation of the vascular system in the possible genesis of ulcer on the basis of spasm rather than organic changes will presently again be considered.

THE CHEMICAL OR CORROSIVE THEORY

The belief that the gastric juice is a factor in the development of so-called peptic ulcer has already been pointed out. Sippy and his pupils, Hurst and Stewart, and many others have emphasized the essential part played by hydrochloric acid and pepsin, especially the former, in the formation of gastric and duodenal ulcers in man; whereas, in the experimental animal, Mann, Ivy, Dragstedt, Harper, and others demonstrated the importance of the chemical properties of the gastric juice in the development of ulcers. The arguments for the peptic genesis of gastric and duodenal ulcers have been ably summarized by Matthews and Dragstedt, and by Lindau and Wulff. These authors argue that it would be impossible to explain the origin of ulcer in a Meckel's diverticulum or in the jejunum following gastrojejunostomy from any other standpoint. I am fully aware of the fact that there are many physicians who are by no means disciples of this viewpoint and who refuse to prescribe neutralizing or absorbing agents in the treatment of ulcer. There are even some who chide those who "Worship at the altar of hyperacidity". But my daily observations impress me convincingly with the importance of gastric hypersecretion in genesis and symptomatology in the large majority of cases of ulcer; and I concur with Crohn that "One cannot disregard the idea of acid and its effect on ulcer without coming to an impasse".

THE GASTRITIS THEORY

That gastritis preceded the development of ulcer was an opinion advanced by Cruveilhier more than a hundred years ago. In the last fifteen years much attention has been paid to this idea, especially by European workers, who have reemphasized its importance. The contributions of Konjetzny and his followers are especially noteworthy. Briefly stated, they hold that ulcers never develop in a healthy mucosa, but are always found on the basis of a previous inflammatory process. My own observations incline me to believe that gastritis in its hypertrophic form, in association with erosion or ulceration and a normal or hypernormal gastric secretory function, occasionally gives rise to the chronic calloused ulcer. It is also highly probable that

chronic gastric ulcers in association with achlorhydria or hypochlorhydria, as well as with carcinoma, as recently pointed out by Maki-shima, may have had their origin in a pre-existing gastritis.

INFECTIOUS THEORY

The possibility of an etiological relationship between bacterial infection and peptic ulcer was based on the familiar clinical and experimental observations of Billings and Rosenow, which were undertaken about a quarter of a century ago. These researches are distinctly an American contribution to the problem. By the infectious theory is meant that the usual form of gastroduodenal ulcer may be attributable to a localized infection by streptococci which have special selective affinity for the mucous membrane of the stomach and duodenum.

Certain clinical observations lend support to this theory. The inception or reactivation of ulcer frequently occurs during the months when streptococcal infections of the upper respiratory tract are present. The same is true following devitalization of teeth, or after an attack of tonsillitis, or after tonsillectomy. An attack of sinusitis may have a similar influence. The cessation of ulcer-simulating gastric disturbances, and even gastro-enteric hemorrhage (probably the result of acute recurring superficial lesions) frequently follows the removal of dental, tonsillar, or prostatic foci.

Critics of the hypothesis of infection argue that this mode of origin would not explain the incidence of the disease as regards sex and age, or the greater preponderance of duodenal ulcers in both sexes; nor would it satisfactorily explain the recurrence of ulcer in cases in which all tangible foci of infection had been removed. Moreover, lesions may heal in the presence of extensive foci following treatment and even spontaneously. The pure Negro in a rural environment is as subject to focal infection as is the white man, if not more so, but he is singularly free from peptic ulcer. Mann has repeatedly observed that the hemorrhagic erosions or acute ulcers reproduced in the rabbit by inoculation of organisms cultured from the foci of human beings rarely if ever develop into the typical chronic lesions; the organisms

found in such experimental lesions he regarded as secondary invaders.

In view of these conflicting facts, the hypothesis that infection is the sole cause of the chronic lesion cannot be unreservedly accepted. That certain microorganisms may prove to be the exciting agents, and on occasion may be the exclusive cause of the lesion, is extremely likely. Other aspects of focal infection are the presence of intraabdominal lesions like appendicitis, which may reflexly, or as a cause of ascending infection, engender an ulcer. Certain observers are also convinced that focal infection may increase the irritability of the autonomic nervous system, thereby giving rise to a condition favorable to the genesis of ulcer. However we may feel about it, it seems the better part of wisdom to remove all obvious foci in ulcer-bearing patients.

TRAUMATIC THEORY

The factor of trauma in the genesis of acute and chronic peptic ulcer has been a subject of contention for many years. Trauma may be of an external or internal nature. The former may even be nonpenetrating in character. Although numerous reports of cases appear in German and French writings, contributions to the subject in English are strikingly few. In recent years, however, several authentic cases of ulcer following external trauma have been reported by competent American observers. Acute as well as chronic calloused ulcers occasionally arise as the result of internal trauma, chiefly in cases of congenital or acquired diaphragmatic hernia, or in association with foreign bodies such as hairballs and persimmon bezoars, and with pointed objects such as needles, nails, and toothpicks swallowed accidentally or with suicidal intent. Many of these lesions are not of the calloused variety, and they may readily heal on removal of the foreign object or with repair of the hernia. While it is not improbable that physicians have been insufficiently cognizant of the part which trauma plays as an initiating or causative factor in gastric and duodenal ulcer, it is my opinion that it plays a decidedly negligible rôle in the rank and file of cases.

MECHANICAL THEORY

The theory that ulcer is of mechanical origin was fostered by Aschoff's observations on hemorrhagic erosions, and the significance of the anatomic and physiologic characteristics of the "Magenstrasse" which made the mucosa in this area more vulnerable. The taut folds, smooth surface, rather fixed mucosa, and the function as a constant pathway for food and fluids, in which pathway acute lesions continue to gape, also led to longer exposure of acute erosions to the gastric juice and tended to lead to chronicity of the lesions. From an experimental standpoint, Mann and his associates have also stressed the importance of the mechanical factor. They emphasized the fact that an ulcer develops at the site where the mucosa is subjected to the greatest force of impingement of the gastric chyme as it is projected from the stomach in a nozzle-like manner. Moreover, the traumatizing effect of poorly digested food, of course, is also an experimental fact. It might be said in passing, however, that the mechanical factor, while a highly important one, is not the sole one; but it undoubtedly has a direct bearing on extension and chronicity of the lesion.

ENDOCRINE THEORY

From time to time the pathogenesis of ulcer has been attributed to dysfunction of the endocrine glands. While derangement of gastric function is common to the endocrinopathies, as a result of the intimate functional interdependence of these glands to the autonomic nervous system and viscera, such diseases apparently bear no direct relation to the genesis of ulcer. Experimental research in this field has on the whole been inconsequential. Crile has been a leading exponent of sympathico-adrenal hyperirritability in the development of ulcer, and he has devised a dekineticizing operation, as you know, in cases of intractable ulcer, thereby in his judgment particularly relieving the patient of his own accelerating mechanism. Recent noteworthy investigations of Cutting, Dodds, and their associates establish the importance of the posterior lobe of the pituitary gland in relation to alimentary blood flow and secretion. These English workers predict an

entirely new approach to research on disease in which there is a derangement of alimentary function.

VITAMIN DEFICIENCY THEORY

To what extent vitamin deficiency plays an etiologic rôle has been the subject of extensive clinical and experimental research in recent years. Sixteen years ago McCarrison pointed out the high incidence of ulcer in the native population of certain regions of India; this he attributed to dietetic shortcomings. In various civilized countries clinical observations suggest that manifestations secondary to avitaminosis may often arise in the alimentary tract. To a deficiency of vitamin C, in particular, has been attributed the origin of ulcer at various times, as well as the tendency to gastro-enteric hemorrhage. In my judgment, vitamin deficiency plays a very negligible part in the average case of ulcer. Nevertheless, the great advances made in the science of nutrition have pointed out the necessity of dietotherapeutic measures being adequate in the essential vitamins and minerals, as well as the avoidance of situations during treatment, especially prolonged achlorhydria, which could impair their assimilation.

ALLERGIC THEORY

The rôle of allergy in the causation of ulcer is highly debatable. Several of our prominent allergists have gone so far as to maintain that ulcer is an allergic manifestation, and that the pain of peptic ulcer occurs in the presence of antigenic foods. This contention seems to have been more or less successfully refuted by Long, but it is reasonable to presume that such common allergens as milk, eggs, and wheat, foods which figure prominently in ulcer diets, can give rise to a persistence of symptoms in allergic ulcer-bearing individuals. I am also of the opinion that such alimentary allergens may sometimes give rise to the hypertrophied pylorus of adults.

NEUROGENIC THEORY

It is a fact of common experience that there exists an intimate relationship between the *emotions* and visceral functions. The effect of the emotions on the digestive function is par-

ticularly striking. For years clinicians have observed that the symptoms of ulcer can be initiated, or may recur, under conditions of psychic and nervous disturbance and fatigue. Moreover, such symptoms can be ameliorated, or they may entirely disappear with the subsidence or removal of these provocative factors, often with striking rapidity. As time went by, physicians perceived that most ulcer-bearing patients have certain mental and nervous features, characterized more or less by restlessness, fear, worry, aggressiveness, hyperreactivity to external stimuli, and sometimes by overweening ambition, overconscientiousness, and so forth, "Kinetic individuals whose efforts make the intensity of modern civilization".

The importance of psychic trauma in the development of peptic ulcer has been emphasized by Rivers. Among 200 medical specialists he found that approximately 20 per cent had ulcer and another 20 per cent had to take soda at intervals. The importance of the psychogenic rather than the racial factor in the causation of ulcer was recently pointed out by Steigmann. The American Negro, transplanted from his usual rural environment in the South, where he is comparatively immune to the disease, to the more intensive industrial milieu of the North, becomes increasingly susceptible to ulcer. Menninger was of the opinion that this fact practically nullifies the constitutional theory. Psychiatrists with Freudian leanings would probably explain the phenomenon as a result of the anxiety arising from development of a strong superego which the occidental civilization engenders. Draper, Robinson and others recently expressed the conviction that emotional conflict in an individual with an ulcer diathesis is alone essential to the production of the disease. So now many of us feel that such disorders and diseases as hypertension, irritable colon, neurocirculatory asthenia, bronchial asthma, hyperthyroidism, diabetes, ulcerative colitis, many premature and so-called degenerative lesions of a cardiovascular-renal nature, and gastric and duodenal ulcer, may be of *psychogenic* origin. The attempt to prove the psychogenesis of somatic disease without departure from a biologic attitude has opened up

an extremely fascinating though difficult field in medicine.

To the German school largely belongs the credit for recognizing the importance of a derangement of the nervous system in etiologic considerations of peptic ulcer. Since 1918, von Bergmann has expressed the belief that disharmony between the vagus and splanchnic systems (parasympathetic and sympathetic) produced localized or generalized spasm in the muscles of the stomach, duodenum, or terminal blood vessels. As the result of such dysfunction, areas of submucosal ischemia or of decreased resistance developed, and resulted eventually in the formation of mucosal erosions through action of the gastric juice. Recently von Bergmann reported that he has observed gastroscopically the development of such lesions from the initial stages to the fully developed *ulcus callosum*.

Kuntz has stated that *parasympathetic hypertonus* in association with gastric and duodenal ulcers has long been recognized. He cited important clinical, pathologic, and experimental observations in support of this contention. In view of the newer knowledge concerning the chemical mediation of autonomic nerve impulses, it was to be anticipated that etiologic concepts based on the influence of the parasympathomimetic factor, acetylcholine, would be advanced. Necheles' observations in this respect are of appropriate interest. Cushing's significant observations, reported six years ago, emphasized the rôle of the autonomic nerves in the genesis of peptic ulcer. He pointed out the importance of influences emanating from the cerebral autonomic nerve centers, especially those in the diencephalon. The experimental observations of Bard, Fulton, Ranson and his associates, and numerous other investigators, are throwing much light on the neuro-anatomy and neurophysiology of these important structures with reference to visceral function and disease. Thus the autonomic nervous system and its central origins, closely identified with the psyche, receive ever-increasing recognition, as has recently been pointed out by Stone.

In many respects inseparable from the psychoneurogenic concept of visceral disease was the more strictly endogenous one of individual

predisposition, which implied hereditary or constitutional factors or diathesis. While the physician, according to Pearl, tends to think particular diseases or pathologic processes are chiefly of exogenous (traumatic, infectious, and so forth) origin, the biologist regards them as of both exogenous and endogenous origin (general or specific constitutional peculiarities), both playing important, though not necessarily equal rôles. In support of the theory that underlying ulcer is a constitutional factor or diathesis, is the familial occurrence of ulcer in a certain percentage of cases, and the remarkable tendency for a small group of ulcer-bearing individuals to form one recurrent ulcer after another in spite of what seems to be adequate prophylaxis and safeguards.

Granting the existence and importance of an inherent factor which predisposes to the development of ulcer in certain individuals, and to which many authorities subscribe, it is obviously difficult to determine what constitutes this factor and to make proper appraisal of its etiologic significance. The attempts of Epinger and Hess, and of Draper, Hurst, Müller and Heimberger, Kalk, Macklin, and Riecker, to mention just a few, to determine the nature of the ingrained characteristic or diathesis, are familiar to most of us. All the premises and conclusions of the investigators in this field have been challenged in many quarters and much controversy exists.

In my judgment, and in that of many others, the factor of *inheritance* can only be definitely determined by careful genetic studies based on single and double ovum twinning. Draper's conclusions with respect to the psychologic factors characteristic of the "Ulcer constitution" have received wider acceptance than those concerning the anthropometric relations.

Reverting now to a discussion of the exogenous and endogenous factors and their respective rôles in the genesis of ulcer, my personal experience impresses me with the importance of the former. Pearl has pointed out that such organ systems as the respiratory, cutaneous, genito-urinary and alimentary tracts, "Come normally and regularly into direct and immediate contact with the external environment; while other organ systems do not, but

are on the contrary protected from such contact". From the experimental standpoint, Mann has stressed the importance of chemical and mechanical factors in the development of the lesion, the importance of an increase in the susceptibility of the mucous membrane to ulcerative processes from the pylorus downward, and the traumatizing effect of coarse particles of food.

The exogenous factor is best exemplified perhaps by the fact that jejunal ulcers may develop following gastrojejunostomy in cases in which patients actually have never had ulcer. How else can one explain the great preponderance of ulcer in males, and particularly recurrent ulcers in this sex? It does not seem that anatomic or gonadal factors are a logical explanation. As has been pointed out, ulcer is a rare disease in the pure Negro, especially in his native habitat, yet Bergsma called attention to its relative frequency in the black people of Abyssinia, where frequently it is attributed to the high content of red pepper in their diet. Thus in various and sundry ways can the importance of the exogenous factor be exemplified.

THE AUTHOR'S OPINION

All noteworthy contributions to the etiology of ulcer in the past decade are in agreement to the effect that ulcer is not the result of a single agent, but is a product of the interaction of various agents; and that the constitutional or systemic factor—to me an aggravatingly intangible one—is fundamentally essential. The other factors vary in nature and importance according to the personal viewpoints or convictions of the respective observers. Thus it seems that, while we have learned much, the mystery of genesis still appears to remain.

I feel that the major facts of the genesis and development of ulcer have been established. Obviously no single theory will hold up under the combined critical analysis of the physiologist, the clinician, and the pathologist. It is my personal opinion that, on occasion, a single factor can play the predominant, if not the exclusive, rôle in the causation of the lesion. I have particular reference to such factors as certain forms of trauma of a mechanical or

chemical nature, to atherosclerosis, gastritis, and focal infection. But I am also of the conviction that such instances are the exception rather than the rule; and that the causative factor which is operative in the vast majority of the cases is the *psyche* mediated through the autonomic nervous system, thus engendering a morbid physiologic state conducive to the initiation, extension, and chronicity of the lesion. To what extent inheritance or constitution, that is a natural predisposition, plays a part in this large group I cannot say; like many psychiatrists, however, I feel that conscious and unconscious emotional factors which can be operative continuously are sufficient.

TREATMENT

In light of the foregoing, how shall we be guided in the treatment of a patient with a known ulcer in a real attempt to heal the lesion and keep it healed? Aside from the chronicity of the lesion and the presence or absence of complications, we are first concerned with the question of *sex*. Other things being equal, ulcer in a female, irrespective of location, is likely to heal more readily than a similar ulcer in a male.

The next concern is the *location* of the ulcer. If gastric, even though the lesion is small and circumscribed, it is essential to exclude the occasional *malignant* ulcer. Table 1 will be found to be helpful in differentiating a benign from a carcinomatous ulcer. In this respect the response to treatment, *subjectively and objectively*, is only less decisive than histologic examination of the excised or resected lesion. If the ulcer is duodenal, the response to treatment is slower, and recurrence is more likely, but there need be no fear of carcinoma. According to Kalk, the stronger the hereditary factors, the earlier the ulcer may be expected to appear and the more severe will be the form taken by the disease. In my experience this is fortunately not always true.

When propitious, tactful inquiry should be made into the social, domestic, economic, and psycho-sexual life of the patient. The calm exterior appearance or deportment of the patient may be misleading. It is illuminating how completely the causes underlying personality

disorders can be ascertained through daily visits to patients undergoing treatment in the hospital. There, suitable privacy is possible, and the patient's confidence can be properly cultivated. The addition of a psychiatrist to the staff of physicians and surgeons of the gastro-enterologic clinics of large institutions makes possible a complete psychobiologic study of the individual. Naturally, once anatomic change has taken place, irrespective of how much a psychogenic factor may have been responsible, the conventional treatment for ulcer, including sedatives and antispasmodics, should be instituted. However, the removal of emotional conflicts and correction of faulty mental habits, if possible, is essential in preventing recurrence.

There have been no significant changes in the dietotherapy of the ordinary uncomplicated ulcer. The guiding principle still consists in the selection of food devoid of chemical, mechanical, or thermal irritation, of adequate vitamin and mineral content, and of caloric value sufficient to meet the individual requirements. Powdered whole milk is advocated in place of the standard milk and cream mixture, if the latter does not prove suitable or convenient. In patients with hemorrhagic tendencies not due to erosion of one of the larger arteries, a sufficient intake of vitamin C is made possible by the addition of large quantities of strained orange juice to milk, as recommended by Blankinship and Oatway.

Methods of *drug therapy* other than parenteral largely aim at the control, neutralization, or absorption of excess gastric acidity and secretion. We are all familiar with the conventional procedure. The continuous, alkalized milk or aluminum hydroxide solution drip method, has certain advantages, and should be employed in those cases resistant to the ordinary methods. According to Wosika, tablets of alkalized, powdered whole milk also may prove an effective and convenient mode of administration. Complete neutralization is not necessary to promote healing. Dragstedt has shown that the threshold value for the digestion of living tissue lies between 0.10 and 0.15 per cent of free acid (97 to 146 mg. of acid chloride per 100 c.c.). Under those circum-

stances which precipitate alkalosis or extra-renal uremia, substitutes for the ordinary alkalis may be found in the tribasic phosphates, hydrated magnesium trisilicate, kaolin, and aluminum salts, jels and creams.

Parenteral methods of treatment are much in vogue even though the rationale of the use of the preparations employed is seriously questioned. Such preparations, and *histidine hydrochloride* in particular, may give complete relief; and cures, usually of a temporary nature, have even been reported. In my judgment, these innovations for the sole treatment of chronic peptic ulcer will be short-lived.

"Alkalosis", and "Nondiabetic acidosis", is a frequent occurrence and constitutes an emergency incident to certain forms of treatment, preoperative states, or postoperative complications. Of less frequency and gravity is *hypo-proteinemia*, an important cause of edema and postoperative impairment of gastric motor function. The successful management of these common gastro-intestinal emergencies necessitates their timely recognition and the prompt institution of adequate therapeutic measures.

Failure of medical treatment can usually be attributed to its insufficiency, as emphasized by the late Lord Moynihan. This is particularly

	Favors Malignancy	Favors Benignancy	Degree (basis of 1 to 4)
Long duration of symptoms (ten years or more).....		+	3
Age, thirty years or less, and free HCl, 40 units or more..		+	3+
Late onset and elderly patient.....	+		2+
Irregular syndrome	+		2
Achlorhydria and obstruction	+		3+
Meniscus sign complex	+		4
Large niche	+		3
Irregular outline of niche	+		3
Location: Prepyloric, greater curvature, posterior wall..	+		2+
Local tenderness (on roentgenologic examination).....		+	3
Incomplete results of treatment	+		2+
Hourglass (B) type of stomach		+	3

TABLE 1

DIFFERENTIAL DIAGNOSTIC FEATURES OF CARCINOMATOUS AND BENIGN GASTRIC ULCER SYMPTOMS AND SIGNS

The treatment of profuse *gastro-enteric hemorrhage* has undergone some changes, the usefulness of which has not yet been fully determined. Meulengracht recommends that patients be given a full diet, of a puréed nature, together with an alkaline mixture three times daily; and extract of hyoscyamus and ferrous lactate from the first day of their admission. His procedure has been acclaimed by numerous observers at home and abroad. We at the Clinic have found the Witts modification more desirable. Continuous forms of *blood transfusion* have been recommended by Marriott and by Silverman. Because of certain undesirable side effects, *dilaudid* may be substituted for morphine when the use of an opiate is indicated.

Toxemia, variously designated as "Extra-renal uremia", "Hypochloremic azotemia", or

true if a proper selection of the patient for treatment has been made, and if the patient's coöperation is all that one could desire. In my judgment it is just as important to *keep the lesion healed* as it is to heal it. This can only be accomplished by a campaign of education, which is best carried out while the patient is hospitalized. This consists of a series of *illustrated lectures* from time to time in which the simple fundamentals of the nature of the disease, and the principles and purposes of treatment are outlined. The baneful effects of those exogenous factors, emotional disturbances, and especially worry and anxiety, nervous and physical fatigue, unhygienic habits of living and eating, of focal infection, the irritant and deleterious effect of alcohol, tobacco, condiments and of stimulating or coarse foods, and hurried, improper mastication, are properly

stressed. Only by this procedure can consistent coöperation be obtained and better end-results expected.

CONCLUSIONS

Chronic gastric and duodenal ulcers can undoubtedly be caused by any one of various factors, or by the interaction of several factors. The predominant or exclusive etiologic factor in the occasional ulcer is focal infection, gastritis, vascular disease, and trauma of a mechanical or chemical nature.

In the majority of cases a neurogenic or psychogenic origin, in whole or large part, appears the most likely. Evidence is submitted to support the contention that the psyche, mediated through the autonomic nervous system, engenders morbid gastric secretory and motor disturbances conducive to the genesis and development of ulcer.

Therapeutic measures based on these etiologic concepts and recent innovations of proved worth are described.

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DISCUSSION BY SIGURD W. JOHNSEN, M.D., PASSAIC, N. J.

I consider it a privilege to discuss a paper by Dr. Eusterman. I know we all feel greatly indebted to him for coming here today to discuss the etiological factors and latest measures of treatment for this prevalent disease.

I have been very much interested in the revival of interest in the neurogenic theory of peptic ulcer origin. One important factor in this revival has been the noteworthy demonstration that acetyl choline is produced by stimulation of the parasympathetic nerves. This fact has opened up the entire discussion of relationship of nervous influence in the production of ulcer.

Neeheles, in his paper before the American Gastro-Enterological Association last year, claims that he has demonstrated a vaso-constricting action on the blood vessels of the stomach and duodenum after injecting small quantities of acetyl choline into the circulation. The resulting anoxemia he interpreted as the cause of peptic ulcer. I have not seen any reports confirming or denying his findings, but a new approach to the etiology of peptic ulcer has certainly been opened up.

Every case of peptic ulcer, in my opinion, should have an individualized therapeutic regime. Diet and control of acidity should be the major factors around which the therapy centers.

In the control of excessive acidity I prefer the tri basic calcium and tri basic magnesium phosphate, as advocated by Kantor. I have used the trisilicate of magnesium, but often it is too slow in action to produce the desired results; and in other cases I have noted an increase in pain rather than a decrease. In some instances, however, I believe it is excellent.

The various intravenous or intramuscular preparations of histidine and emetine derivations I have never used, because I have never felt there was any satisfactory therapeutic basis for their use.

Obstinate pylorospasm, or stricture, which cannot be controlled by a strict medical regime, calls for operative interference. Whenever conditions permit, I prefer gastric resection as the operation of choice. When resection is not advisable because of technical difficulties or surgical risk, then posterior gastro-enterostomy is advisable.

DISCUSSION BY LOUIS L. PERKEL, M.D., JERSEY CITY, N. J.

Not until the exact etiology of peptic ulcer is determined will there be a scientific rational treatment of this condition. The multiplicity of treatments advised is proof of our ignorance as to the genesis of ulcer.

As Dr. Eusterman has emphasized, the neuro-psychogenic factors of ulcer are of utmost importance in explaining both etiology and recurrences.

The frequency of duodenal ulcer in brothers and sisters is perhaps more than coincidental. This apparent familial tendency may have deeper significance than our present knowledge of genetics can explain.

At the Jersey City Medical Center, in a rather extensive experience with peptic ulcer, in the last few years we have routinely used aluminum hydroxide colloidal solution in place of the usual alkaline salts. The well-known tendency of the latter to produce a secondary rise in acidity (rebound), and occasionally an alarming alkalosis, has prompted us to use the

alkalies only in those few cases in which aluminum hydroxide failed to relieve symptoms. Our experience with parenteral medication such as histidine and emetine preparations has been disappointing.

In our gastro-intestinal clinic each ulcer patient receives a printed list of instructions advising him in simple language the principles of physical and mental hygiene so necessary to the healing of his ulcer. Besides the physical examination, the patient is also studied psychologically, and appropriate advice is given. Thus by education and encouragement the greatest amount of coöperation is obtained from the patient.

When surgery is definitely indicated, we advocate sub-total gastrectomy, rather than gastro-enterostomy. The latter operation is reserved for special cases where resection would be too great a risk, and for cases of complete pyloric obstruction with low acidity in which this operation produces its most spectacular results.

A CASE OF TETANUS

By DR. NATHANIEL MANNING, Amboy, Middlesex County, N. J.

Reprinted from the Transactions of The Medical Society of New Jersey, 1766-1858, page 139. It was apparently presented to the Society on June 8, 1813.

Dr. Nathaniel Manning was the son of a clergyman of that name who practiced medicine in Amboy and Piscataway. The father was in Princeton College as a clergyman, and then studied medicine in the University of Pennsylvania. He was a member of The Medical Society from 1767 to 1772, when he went to England and was ordained by the Bishop of London, and then was rector in Hampton Parish, Hampton County, Virginia.

The record of his son, Nathaniel Jr., is meager, but honorable. He was accepted as a member of The Medical Society of New Jersey on June 23, 1807, and gave one of the infrequent papers which were read before it in its early days. The Transactions, page 155-159 contain a paper by him on "A Case of Psoas Abscess" which he read before the Middlesex County Society on September 4, 1816.

Dr. Manning served on committees of the State Society, and attended eleven of the eighteen meetings which were held up to 1824. Afterward his name no longer appears on the minutes.

J. H. of South Amboy, in the year 1813, a robust, healthy man, of sanguine temperament and inured to hardships, was chopping down a tree and brought his axe down upon his left temporal bone, forming a small, deep wound, which soon closed up and prevented any discharge for several days, during which time he was exposed to a severe northeasterly storm, in the last of March, by which he caught a violent cold, and affected the wound particularly. At this time he had not called any medical aid. The wound had now been standing three weeks, and he considered himself perfectly well, until after the exposure.

The first sensation was a pricking and slight pain in the wound, extending down the muscles of the face and lower jaw, which was soon followed by a stiffness of that side of the neck, with an inclination of the head to that side, and an inability to open the mouth, even to take drink. He now became alarmed, and in this situation he called at my office for advice, but not being in, I did not see him; obtained some salts, and was advised to apply a warm poultice to the part affected. The salts operated very well, without any sensible relief. As I was not requested to visit him at the time, he neglected to send for me until the second day after, when I visited him and found him in a complete universal tetanic affection, which had rapidly increased after he left my office. His pulse was frequent, but small, his countenance pale and much distorted, a cold clammy

sweat on the head, breast, and superior extremities, a dryness of the lower extremities, but also cold, excruciating pain, and frequent spasmodic contraction of the different parts of the system.

The want of a discharge producing a morbid irritation in the nervous system, formed the indication of a cure. In order to effect this, I immediately laid open the wound the whole extent, applied spts. terebinthinae and finely powdered cantharides, to inflame as quick as possible, over which was laid a warm cataplasm of bread and milk, to favor a discharge. The case appeared hopeless, as the whole system was in a rigid spasmodic contraction; like a stick of wood, he could be raised on his feet by the back of his head. The second indication was to relax the contractions and lessen the spasms, and thirdly to support the system, until this could be effected. After clearing the *prima via*, which appeared constipated, directed a teaspoonful of laudanum to be given every hour for several hours, interposing a bolus of cal, camphor and opium, which was with difficulty effected through a small opening between the back teeth; a blister was laid behind the ear and side of the neck, and kept discharging by ungt. cantharidi.

The next visit, on the following day found no sensible relief, but the symptoms more alarming, the pulse became irregular and weaker, and the spasm more frequent. Frictions of laudanum and terebinthina were ap-

plied; the laudanum and boluses continued, but increased in quantity; brandy was given liberally.

Third day. Found all the symptoms increased, if possible; a hurried and impeded respiration, the countenance sunk, and a staring wildness, with a spasmodic fixtured of the eyes; the presumption was that death would soon release him from his sufferings. The wound was penciled with caustic and dressed as before; the bolus is continued, brandy and wine also, but to the laudanum was added ol succini (amber) gtt 12, and tinct. cantharides gtt. 20, five or six times a day. Friction continued, and an epispastic (blister) to the thorax.

Fourth day. Much the same as before, except the wound began to digest a little, the calomel began to act on the bowels and was discontinued; with the brandy, etc. as before, but somewhat increased.

Fifth day. Under the treatment he continued much the same, except the pulse rose a little, and some symptoms of pyalism, but the rigidity and spasms nearly as violent as before.

Sixth day. There was evident abatement of all the symptoms in a degree not to have been expected. The jaws became open that a spoon handle can be thrust between the teeth, and took nourishment better and more in quantity. The same course pursued as before. The wound dressed with common digestive ungt.

Seventh day. He is much improved, the spasms relaxed considerably, the pulse more regular and less frequent, a general warmth pervades the system, respiration tranquil and perspiration less profuse, the wound granulates healthy. The same means persevered in, though in a lesser degree. The tinct. cantharides lessened as there was some strangury produced.

Eighth day. Still improving, can walk with being supported; omitted the cantharides and gave dose of sal gaulther; continued laud. ol succini camph. and opium occasionally, substituted the bark at intervals, and I had the pleasure of seeing him the next day walking alone and able to eat tolerably well, when I discontinued my visits. The wound had healed up very nearly.

LIVING CONDITIONS

I must here remark that the situation of this man was truly miserable in every respect; the apartment was a small house, two families within but one room, and no windows that admitted light; the only avenue was the door, which was always partly open. Being in indigent circumstances, his attention and attendants were no better than his apartment.

PNEUMONIA

He continued improving some time; but I have yet to lament the final termination of this case. A storm came on which lasted several days, by which he caught a new cold, that concentrated upon his lungs. Several days elapsed before they could cross the ferry to inform me of the situation, which, when I saw him, had the appearance of a true peripneumony, far advanced, and terminated the next day mortally.

Although this case in the end proved unfavorable, yet it goes to show that the remedies made use of were efficient in removing or relieving the tetanic affections, and deserve a further trial. If the circumstances had been favorable, I should have tried the warm and cold bath in succession, probably. Several other cases of lesser magnitude have occurred, when I have applied the above means with happiest effect.

AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY COMMITTEE ON MATERNAL AND INFANT WELFARE

MATERNAL WELFARE ARTICLE NUMBER THIRTY-SEVEN

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.
Chairman, Membership Committee for New Jersey

The American Congress on Obstetrics and Gynecology is sponsored by the American Committee on Maternal Welfare. This committee is composed of member organizations with a representative from each forming the Board. The member organizations include the various national and sectional obstetrical and gynecological associations, hospital associations, public health organizations, and nursing associations.

The Central Association on Obstetrics and Gynecology proposed an American Congress on Obstetrics and Gynecology to study the present-day problems on obstetrics and gynecology and their solution. The American Committee on Maternal Welfare was asked to sponsor this Congress. The Congress will be held in Cleveland, Ohio, September 11-15, 1939. The committee expresses the purpose of the Congress, "To present a program of our present-day medical, nursing, and health problems, from a scientific, practical, educational, and economic viewpoint as far as they relate to human reproduction, and maternal and neonatal care." This Congress is not in any sense a legislative body and naturally will take no action relative to maternal and infant care.

There will be sessions for each professional group in the morning with round table discus-

sions. The afternoon meetings will have papers of general interest to all members attending the Congress. The public will be invited to the evening sessions where there will be speakers of national prominence.

The program for the physicians will include, among many others, such subjects as pregnancy associated with thyroid disease, heart disease, diabetes, tuberculosis, nutritional factors, carcinoma of the female genitive tract, and abortions.

The Congress is not planned as a meeting for specialists in any sense of the word, but for all physicians who are interested in the problem of maternal and child welfare. Your committee highly recommends this Congress as a week of post-graduate work which should be worth while much more to the physician than the time and expense incurred for the trip. The physicians of this State should be well represented as this Congress.

The membership fee of \$5.00 includes membership in The American Committee on Maternal Welfare, and registration in The American Congress on Obstetrics and Gynecology. Application blanks and further information may be secured from your chairman, or from The American Congress on Obstetrics and Gynecology, 650 Rush Street, Chicago, Illinois.

A LESSON FROM A DEATH CERTIFICATE NUMBER NINE

Patient, age thirty-two years; para i; gravida ii. History of stillbirth with first pregnancy after being in labor seventy-two hours.

Admitted to hospital in labor with membranes ruptured before labor began. After twenty-four hours more of labor, a cesarean was done. Blood pressure high. Died on eighth day of generalized peritonitis.

This case brings out two points:

1. The danger in doing a section after a long labor with membranes ruptured.

2. Inadequate prenatal care through which the patient became toxic, and was not marked for a possible cesarean before labor had progressed far or before labor began on account of previous history.

A. W. BINGHAM, *Chairman,*
Maternal Welfare Committee.

THE PRESIDENT'S PAGE

NUMBER THIRTEEN

THE YEAR IN REVIEW

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

"La reconnaissance est la mémoire du coeur." This is my last page. It will reach you just before our distinguished and universally loved President-Elect, E. Zeh Hawkes, assumes office. Though I write from a full heart, what I write will soon be forgotten. The Journal will be filed away among dust-covered archives. The page itself will turn sear and yellow, but gratitude is eternal. Gratitude is etched on the memories of the doctors of New Jersey, and engraved on the hearts of the lame, the halt, and the blind.

It is a pleasure, albeit the last, to express for the medical profession of New Jersey appreciation to the officers, trustees, and committeemen of The Medical Society of New Jersey. Their work has been well done. Your President travelled 23,980.4 miles by air, rail, and automobile, and talked with doctors everywhere, young and old,—with family doctors and with specialists, with institutional men and private practitioners, with doctors of high and low estate. Gratitude among them is universal. Without exception they appreciate the tremendous sacrifice made by more than three hundred members of the official family of The Medical Society of New Jersey. Moreover, their work is appreciated by laymen. Governor Moore and the various departments of state, the allied professions and the public have shown their unmistakable gratitude on many occasions. "Beneficiorum gratia sempiterna est."

APPRECIATION OF THE MEDICAL PROFESSION

At the beginning of this administrative year, certain dangers seemed imminent, and certain obstacles seemed insurmountable. The threat of socialized medicine hung over us like the sword of Damocles. There were those in high places who tried to place the sick and their care under the control of politicians. These agitators were vocal, resourceful, and aggressive. Although they stormed the gates, they did not capture the citadel. For this we are grateful.

A year ago public confidence in the profession had reached an all-time low. We, as an integral part of the American Medical Association, stood indicted at the feet of blindfolded Justice. While the individual doctor retained the respect of his patients, the public at large began to cast the jaundiced eye of suspicion at organized medicine. Some officials

of the Federal Government hurled anathemas and uttered phillipics against us. The *doctor* was deified; the *profession* was damned. This apparent enigma is not hard to understand. For many centuries, the profession enshrouded itself in a mantle of mediaeval reserve. We shunned the forum and the market place. The people thought us aloof, and regarded our code of ethics as ancient armor to protect ourselves. They did not understand. Moreover, we bore in silence the darts and arrows of cults and quacks that have gathered about them an odd assortment of infatuated followers. The medical profession at long last has cast aside its mantle of mysticism. A well-planned program of public relations is now being carried out. In this State, mutual understanding now exists between the public and the profession. New Jersey law-makers have come to realize that we have no ulterior motives; and that the legislative aims of our profession and the welfare of the public are one and the same. For this we are grateful.

DISTRIBUTING BURDENS OF ADMINISTRATION

At the beginning of this administration certain intrinsic obstacles to progress seemed insurmountable. Most doctors have little time or energy to puzzle over the problems that affect the profession as a whole. They are too busy with their own patients. While vaguely aware of what is going on just beyond the horizon, there are so many clamorous demands on them, morning, noon and night, that what appears to be *indifference* is really the *inertia of exhaustion*. To get work out of exhausted men is no small task. Moreover, the work of the Society has grown by leaps and bounds. In order that no man be given a burden more than he could bear, the load was distributed among three hundred men. The year's work is now done and well done. No one had to retire from practice; no one suffered serious pecuniary loss; and now, after thirteen months, these three hundred men still bask in their wives' unalienated affection.

OFFICERS AND COMMITTEES

To every one of the eighteen members of the Board of Trustees, we are eternally grateful. There have been thirteen meetings of the Board, with an attendance of 86 per cent. Not only has the Board laid down wise policies and

solved intricate problems, but for the first time its members have served as *consultants* to the several committees. This participation in committee work has been mutually beneficial. It kept the Board in touch with the work of the committees; and it kept the work of the committees in line with the broad policies laid down by the Board. We are grateful everlastingly to the Board of Trustees.

Your President has had opportunity to observe the work of the officers of the Society more closely than most of you. Drs. Hawkes, Morris, and Lewis have attended every Cabinet meeting, every meeting of the Welfare Committee and of the committees on which they served as consultants; and have visited every component county society. Without exception, they have completed every task, large and small, assigned to them.

The Secretary, Dr. Stahl, and the Treasurer, Dr. Marsh, deserve the same unstinted praise. If any of your officers left a stone unturned, I do not know my geology. In your name, I thank them sincerely.

The work of your committees has been a joy to behold. There are forty committees with 353 men serving on them. They held 160 meetings, with an average attendance of 70 per cent. These attendance figures do not include special board committees; the Committee on Honorary Membership, the work of which was to be carried on entirely by correspondence; and the Committee on Annual Meetings, the chairman of which has been in almost daily conference with the President.

Nor do these figures include the frequent meetings of the Governor's Committee on health and welfare, to which sixty-eight members of The Medical Society of New Jersey belong. I know of no State Society the committees of which compare with New Jersey in man-hours spent, or in results achieved.

Finally, but by no means least, we are grateful to headquarters staff in Trenton. The Executive Secretary is an administrator, keen of vision and prompt of action. The Assistant Executive, new this year, has already proven himself invaluable. The Editor of the Journal, with sixteen years of editorial experience, has earned our eternal gratitude. The girls in the office have served us far beyond our ability to pay. It is heartening in these days of short hours and indifferent labor to find a corps of willing workers, to whom overtime means nothing.

TO PRESIDENT-ELECT HAWKES

At the beginning of the year, there remained remnants of sectional strife and provincialism. These have disappeared. This year turned out to be an era of good will and understanding. The Society is marching forward toward worthy objectives in solid unbroken phalanx in step as we pass in review before our new President. We need not mark time while we salute him. Rather let us pledge him allegiance to the cadence of marching feet. He could ask no more from this, the grandest group of men on earth, than the same loyal support so generously bestowed upon your retiring President.

THE YEAR IN ANTICIPATION

By E. ZEH HAWKES, M.D., Newark, N. J., President-Elect, The Medical Society of New Jersey

In response to President Carrington's suggestion, the President-Elect extends his hearty greetings to the officers and members of The Medical Society of New Jersey. It is a particular pleasure to do this, because it also gives opportunity to express appreciation of the courteous and helpful attitude of Dr. Carrington throughout his administrative year, and admiration for his untiring devotion to the welfare of our Society.

The President-Elect cannot expect to have

such a brilliant administration as the one just coming to an end, but he hopes to progress toward a realization of the objectives which have been carefully nurtured during the past year.

The likelihood of the prompt attainment of our objectives increases in direct proportion with the number of members who give active support to the administrative problems. Let us therefore begin the work of the year promptly, and develop it with energy and persistence.

STATE SOCIETY ACTIVITIES

THE IMPLICATIONS OF HEALTH INSURANCE IN AMERICA

THE IMPLICATIONS OF HEALTH INSURANCE IN AMERICA

By J. A. HANNAH, M.D., Toronto, Ontario

Abstract of an address before the Welfare Committee of The Medical Society of New Jersey in Trenton, April 16, 1939.

Only as we as a profession know the problem of health insurance and are willing to cope with it will there be any satisfactory answer. It is suicide for us to allow laymen, political or otherwise, to gain control of this situation. I will outline the experience of the Medical Society of the Province of Ontario in its development of a successful plan of providing medical care to patients of low incomes.

Some of the factors which have led to the present demand for health insurance are:

1. Every advance in scientific knowledge has brought an increased cost in its application to the patient.

2. Formerly it was the custom of the people to save their pennies so as to buy the necessities of life; but now luxuries come first. For example, there is one automobile for every four persons in Ontario, although 94 per cent of earners have incomes of less than \$3000.

3. People buy cigarettes and other luxuries; yet there is as much money spent on them as on medical services, because when one package is finished, another may be bought for a dime; or he can get a smoke from a friend. But he makes no provision for sickness.

SCIENTIFIC INSURANCE PLANS

The medical profession has avoided research and experimentation in the field of voluntary insurance against sickness. It has surrendered its birthright of leadership and has become the handmaid of hospitals and other institutions that were originally designed to be its help-mates. We can add to this the evils of lodge practice, some forms of industrial medicine, and mercenary group practice combines. Each of these is based on purely economic factors and self-gain.

We must meet these conditions in the same manner as we have met our manifold problems in our scientific field. Statisticians, actuaries, and insurance brokers grope hopelessly in their understanding of the problems of medical practice. The plotter of graphs finds his waving line ever deviating from its path of virtue and rectitude. Here is a research problem to challenge the best brains in the ranks of organized

medicine. It will not do for us to regard this particular "Specialty" as something beneath professional dignity. Until medical men are placed in executive positions in hospitals and medical societies, we must expect an extension of non-medical control of medical practice.

We must not expect any negative results in Europe as detrimental to progress in the solution of our own problems. Every process is a growth; and every growth changes in direct proportion to its age. The English and the Danish plans are now undergoing a process of evolution and growth.

No plan offers satisfaction unless the profession establishes within itself some plan of discipline which will permit of free choice of physician.

No plan will be satisfactory until the members of the profession recognize their responsibility and assume a leadership in its application. Just as the patient awaits instructions from the physician of his choice, so the public awaits the leadership of the medical profession.

Every government-controlled plan has started from a purely economic point of view. In America, its basis must be *medical*.

There are three methods of approach to the problem:

1. By legislation, which is a costly system of trial and error, and subject to abuse, and ineffective to the really sick.

2. As an ordinary business project, which excludes any form of service which is not immediately profitable to the proponents of the plan.

3. By coöperation of all the interested parties.

The medical profession of the Province of Ontario set about the development of its own answer by forming the Associated Medical Services Association, Inc. This association was an outgrowth of the Ontario Civic Service Association which started its medical services with contracts with hospitals. But the Ontario Medical Association studied the conditions and in 1937 it appropriated \$5000 to instituting a new plan under full control of the medical profession.

Dr. Hannah here gave the rules under which medical and surgical and obstetrical services were rendered. The rates are such that the initial appropriation of the Medical Association has been returned.

In concluding his address, Dr. Hannah gave the following résumé of the principles on which the estimates of cost were based:

COSTS

In arriving at a basis of service and its cost, we have considered it best to set out the amount of services required by an individual in one year and set over against it the cost on the basis of the minimum schedule of fees as set forth by the tariff of the Ontario Medical Association. This appears as follows:

Home calls—1 per person per year	\$ 3.00
Office calls—1.5 per person per year at \$2.00..	3.00
Surgical operations—0.08 per person per year @ \$50.00	4.00
Consultations and specialist cost per person per year	4.00
X-ray and laboratory work	1.00
Hospitalization—1.3 days, at \$3.50	4.50
Nursing—0.50 days, at \$5.00 per day	2.50
Administration	2.00
Total	\$24.00

These services cover obstetrical and surgical attention under controlled conditions, and the cost totals \$24.00 per person per year in the individual situation. Because of the reduced incidence of service required in the family situation the cost drops 25 cents for each dependent to a minimum of \$1.00 per person. In the average family of four this costs \$6.50 per month, or 5-12/32 cents per day per person. This is less than is spent annually by such average family on smokes, cosmetics, or other luxuries.

Dr. Hannah also gave the following table of the cost of the service to the subscriber:

The subscriber shall pay to the Corporation in advance monthly subscriptions on the following scale:

For the subscriber	\$2.00 per month
For the first dependent of the sub- scriber	1.75 per month
For the second dependent of the subscriber	1.50 per month
For the third dependent of the sub- scriber	1.25 per month
For the fourth and each additional dependent of the subscriber	1.00 per month

RESULTS

The following summary of the operation of the services was also given:

On June 1st, 1937, we opened our offices at 11 Queen's Park, Toronto, in space granted rent-free by the Government.

At the close of 1937, after seven months' operation, we had secured 733 subscribers, and were paying most of our overhead, as well as showing a surplus of \$1,722.00 on our medical reserve account.

During 1938 our subscribers rose to 4,020,—five and a half times the number with which we ended 1937. At the same time our reserve increased almost eight times, leaving sufficient funds to carry our previous experience for three months without income, if necessary. We closed the year with a surplus of \$160.00 in our administrative account, and \$11,000 in our medical reserve account.

Since December 31, 1938, we have had 2500, or 60 per cent, increase in subscribers. Both medical and administrative reserves are showing healthy increases; and on May 30, at the meeting of the Ontario Medical Association, we will hand it a cheque for \$3,800, which will wipe out our indebtedness.

DELEGATES AND ALTERNATES

A COMMUNICATION FROM DR. ALFRED STAHL, SECRETARY, THE MEDICAL SOCIETY OF NEW JERSEY

The following question arose in connection with the seating of the members of the House of Delegates last year, and was referred to our attorney, Mr. Wall, of Jersey City, whose reply has just come to me. The question submitted to Mr. Wall was:

"When a man is elected as a Delegate from his component society and is at the same time an Officer or a Fellow of the State Society, may his alternate from the county society be seated as a Delegate at the annual meeting?"

Mr. Wall's decision was that a Delegate's Alternate may be seated as a Delegate only in

the event that the Delegate is unable to attend the meeting, in which case the Delegate shall assign his Delegate's card to the Alternate. Having done this the Delegate's right to attend that meeting is forfeited.

According to Mr. Wall, however, nothing in Section 3 of Article 4 of the Constitution dealing with the election of Delegates renders an Officer or Fellow ineligible to become a Delegate from his county society. When a duly elected Delegate of a county society is at the same time an Officer or Fellow of the State Society, and thus becomes ex-officio a Delegate, he may resign as a duly elected Delegate

of his county society, but he still may attend the House of Delegates as an ex-officio member. In such case another Delegate may be duly elected by the county society and thus increase the representation from the county society by one member.

It is important in this connection to note that only a *duly elected Delegate* may serve on the Nominating Committee, either as Delegate or Alternate. Ex-officio Delegates cannot

so serve. (See Chapter 5, Section 1, page 16 of the May, 1938, issue of the Constitution, By-Laws and Charter of The Medical Society of New Jersey.)

I have noted in exceptional cases that a county society has elected the same person as *both* regular Delegate and Alternate. The effect of this is, according to Mr. Wall, that the local society has no Alternate Delegate if the regular Delegate is unable to attend. (See By-Laws, Chapter 5, Section 1, page 17.)

BILLS AND EXPENSE ACCOUNTS

The following notice regarding bills and expense accounts has been sent to the State officers and committee chairmen by Treasurer Marsh on May fifth:

"The 1938-39 fiscal year closes May 31st, 1939. The Annual Meeting is held the first week in June. Since it is necessary for the Treasurer to present his annual statement of accounts to the House of Delegates at the Annual Meeting, all bills, all expense accounts, and all salary statements *must* be in the Ex-

ecutive Offices *not later* than the 15th of May, in order that they can be approved by the Finance Committee and still reach the State Society Treasurer before the *deadline*, May 20th.

"No checks will be issued by the State Society Treasurer for bills sent in after the date set."

Fraternally,

ELIAS J. MARSH, *Treasurer*.

THE NEW JERSEY FORMULARY

The Journal of the American Medical Association of March 4, 1939, page 874, contains a review of the Third Edition of the New Jersey Formulary. This is a joint report of the Committee on Pharmaceutical Problems of The Medical Society of New Jersey, and the Committee on Professional Relations of the New Jersey Pharmaceutical Association, as described in The Journal of November, 1938, page 690. The A. M. A. review is as follows:

This booklet opens with suggestions to physicians which include a plea for prescription writing in place of the prescribing of controlled-name products. This section includes the statement that "to combat commercial domination of therapeutics, the Council on Pharmacy and Chemistry of the American Medical Association was formed. Physicians should avail themselves of the help which their own Council can give them."

The booklet contains the usual tables of weights, measures and equivalents, and then suggests various preparations which are designated "N. J. F." (New Jersey Formulary). These are essentially

modifications of the National Formulary preparations included in the book. Typical prescriptions are given for sedatives, elixirs, analgesic capsules, tonics, and carminatives.

The general purpose of this book is excellent. The advisability of suggesting prescriptions to physicians has certain advantages and also certain disadvantages. One item which is obviously designed to supplant expensive proprietary preparations of this type is a baby oil, "Olei Infzntilis, N. J. F.," which contains 12.5 per cent of olive oil in light liquid petrolatum, with one part in 500 of the antiseptic chlorthymol, and oil of rose to perfume. On the whole, this booklet appears to be as useful as similar formularies which are on the market. It is especially designed, however, for use in New Jersey, since it contains the "N. J. F." preparations which those in other states would not be familiar with.

The idea of pharmacists and physicians coöperating in the preparation of such a book is preferable to the plan used in one other state of issuing such information from a joint committee of the Pharmaceutical Association and the Retail Druggists Association.

GASTRO-ENTEROLOGICAL ASSOCIATION

The fourth annual convention of the National Gastro-Enterological Association will be held on June 1 and 2, 1939, in Squibb Hall, Squibb Building, 745 Fifth Avenue, New York City. Sessions will be held in both the morning and the afternoon, with a dinner in

the evening of June first in the Hotel St. Moritz, 50 Central Park South at Sixth Avenue.

Members of the Medical Profession are cordially invited.

NOMINATING COMMITTEE OF THE STATE MEDICAL SOCIETY, 1939

Chairman, William G. Herrman, Junior Past President

<i>County</i>	<i>Delegate</i>	<i>Alternate</i>
ATLANTIC	D. Ward Scanlan	David B. Allman
BERGEN	Arcangelo Liva	Samuel Alexander
BURLINGTON	S. Emlen Stokes	E. J. Haines
CAMDEN	Thomas B. Lee	Reuben L. Sharp
CAPE MAY	Clarence W. Way	
CUMBERLAND	H. B. Walker	H. G. Miller
ESSEX	H. Roy Van Ness	William H. Areson
GLOUCESTER	*E. E. Downs	B. A. Livengood
HUDSON	Joseph F. Londrigan	F. J. McLoughlin
HUNTERDON	A. H. Coleman	S. B. English
MERCER	Harry R. North	D. Leo Haggerty
MIDDLESEX	J. V. Smith	H. Haywood
MONMOUTH	D. F. Featherston	Carlos Pons
MORRIS	Bernard C. McMahon	Byron G. Sherman
OCEAN	Adolph Towbin	Eugene Herbener
PASSAIC	Andrew F. McBride	Charles J. Murn
SALEM	David W. Green	
SOMERSET	D. O. Hamblin	
SUSSEX	H. Aitken	Jesse McCall
UNION	H. V. Hubbard	Herschel S. Murphy
WARREN	Floyd A. Shimer	

*Deceased.

MEMORIAL TO DR. E. R. MULFORD

The following memorial to Dr. Ephraim R. Mulford, of Paterson, who died on March 10, 1939, was adopted by the Passaic County Medical Society on April 12:

Ephraim R. Mulford's last errand of mercy on earth is done. On March 10, 1939, he answered the roll-call which summons all that is mortal to its reward. And while he passes through the Valley of the Shadows, the members of the Burlington County Medical Society bow their heads in silence, and pause to review in loving memory the many qualities which enshrined him in our hearts.

As a member of this Society, and later as its State President, he was ever active in promoting that which pertained to its welfare. We recall his years of steadfast loyalty, untiring devotion, and unflinching courtesy. We remember his kindly nature, his cheerful disposition and willingness to serve. These, and many other equally good traits endeared him to all with whom he came into contact.

His life was eloquent in its unselfish dedication

to an ideal. He was active in the affairs of the community in which he lived. He was diligent in the relief of human suffering. He was conscientious to a fault in that he showed faith and honor beyond the strict measure of debt or obligation. The world of medicine has lost a capable official; we, a beloved friend and associate; and the community at large, a valuable citizen.

And as the memory of his genial presence and great heart abide with us in our loss, so do we extend this heartfelt token of sorrow to his bereaved family, and fervently pray that those upon whom his absence weighs most heavily, may be given strength and peace in this their dark hour.

JOSEPH M. KUDER

J. HOWARD HORNBURGER

JACOB M. DAVIS

I. W. KNIGHT, M.D.

Dr. I. W. Knight was born in Byberry, Pa., June 26, 1882, and died on April 10, 1939. He received his early education at Friends Central School in Philadelphia, and attended the Hahnemann Medical College, where he graduated in 1903. He served his internship in the Hahnemann Hospital in 1903-1904. In 1913 he was affiliated with the staff of the Byberry institution.

In 1915, Dr. Knight became District Health Officer at Pennsgrove and entered the employment of the New Jersey State Department of Health in 1916. He then was designated as State Health Officer for a district of four counties in Southern New Jersey—Camden, Cumberland, Gloucester, and Salem. Dr. Knight was the first official in the

State of New Jersey to have the title of District Health Officer bestowed on him. Until the time of his death he faithfully served in that capacity for twenty-three years. During the World War he served as a Captain in the Medical Corps and was assigned to Camps Dix and Raritan, New Jersey.

Dr. Knight was a member of The Medical Society of New Jersey, American Medical Association, Gloucester County Medical Society, New Jersey Health Officers' Association, and the American Health Association. He was Past President of the New Jersey Health and Sanitary Association.

Dr. Knight was a charter member of the Pitman Kiwanis Club, of which he was a former director and its first secretary. For several years he had

been greatly interested in Boy Scouts. He was a member of the Gloucester-Salem Boy Scout Council and took a leading part in its work.

Dr. Knight was President of the Gloucester County Medical Society in 1931. He was a loyal and helpful member for many years, serving as Chairman of the important Public Health Commit-

tee for several terms. This office he filled with zeal and unusual ability. In the State organization he served on the Welfare and Public Health Committees. Recently he was appointed by Governor Moore to a State Committee for the Study and Control of Pneumonia. His counsel and faithful presence will be missed by us all.

DR. H. L. STRANDBERG

Dr. Herbert Lawrence Strandberg, of Carteret, Middlesex County, died on February 24, 1939. He was born October 22, 1890. He attended the Perth Amboy High School, and took a pre-medical course in New York University. He graduated from the University of Maryland Medical School in 1916, and interned in the Bayonne General Hospital. He served in the Medical Corps of the U. S. Army dur-

ing the World War, and then practiced medicine in Carteret for twenty years.

Dr. Strandberg was active in civic affairs, serving on the Borough Council of Carteret and on the Board of Education. He initiated and supervised the local program for venereal disease control. He was an active member of The Medical Society of New Jersey, and Mrs. Strandberg is President of the Woman's Auxillary to the Middlesex County Medical Society.

BOYD E. WILKINSON, M.D.

Dr. Boyd E. Wilkinson, a noted x-ray specialist, of Paterson, N. J., died on April 12, 1939, from a chronic heart affection. He was born in Trevorton, Pa., June 17, 1880. He graduated from the Baltimore Medical College in 1905, and practiced in his home town for twelve years. He served in the World War as Chief of the X-Ray Department of Evacuation Hospital No. 15 in Verdun, France.

After the war, Dr. Wilkinson began to practice

in Paterson, and became noted as an x-ray specialist in the Paterson General Hospital and the Good Samaritan Hospital.

He was an active member of The Medical Society of New Jersey and of the Radiological Societies of New Jersey and of America. He was also a member of the National League of Masonic Clubs and the Rockaway Hunting Club. He leaves his wife, and his son, Dr. Ralph Wilkinson, of Trevorton, Pa.

DECEASED PHYSICIANS—NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Ellwood E. Downs	48	Mar. 18, 1939	Woodbury	Same	Pulmonary embolism.
Walter W. Gosling	41	Mar. 4, 1939	Neptune	Same	Cerebral hemorrhage.
H. Crittenden Harris	78	Mar. 2, 1939	Glen Ridge	Same	Chronic endocarditis.
Robert R. Sellers	52	Mar. 13, 1939	Newark	Same	Coronary stenosis.
Lettie A. Ward	80	Mar. 18, 1939	Camden	Woodbury Hgts.	Broncho pneumonia.

NUMBER OF CHILDREN REPORTED AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1938

DIPHTHERIA TOXOID

County	Total to Feb. 28	Month of March	Total to Mar. 31	Average per Month
Atlantic	725	3	728	91.
Bergen	2279	114	2393	299.1
Burlington	379	94	473	59.1
Camden	1181	173	1354	169.2
Cape May	356	19	375	46.8
Cumberland	91	6	97	12.1
Essex	8181	528	8709	1088.6
Gloucester	119	151	270	33.7
Hudson	3034	663	3697	462.1
Hunterdon	5	134	139	17.3
Mercer	2274	223	2497	312.1
Middlesex	984	5	989	123.6
Monmouth	305	8	313	39.1
Morris	323	131	454	56.7
Ocean	202	0	202	25.2
Passaic	2025	343	2368	296.
Salem	233	41	274	34.2
Somerset	104	34	138	17.2
Sussex	5	0	5	.6
Union	1126	97	1223	152.8
Warren	366	56	422	52.7
Totals	24297	2823	27120	3390.

SMALLPOX VACCINE

County	Total to Feb. 28	Month of March	Total to Mar. 31	Average per Month
Atlantic	514	5	519	64.8
Bergen	1720	82	1802	225.2
Burlington	251	0	251	31.3
Camden	2191	45	2236	279.5
Cape May	346	1	347	43.3
Cumberland	208	2	210	26.2
Essex	3778	127	3905	488.1
Gloucester	409	1	410	51.2
Hudson	2800	113	2913	364.1
Hunterdon	17	0	17	2.1
Mercer	957	34	991	123.8
Middlesex	1724	7	1731	216.3
Monmouth	1047	3	1050	131.2
Morris	684	70	754	94.2
Ocean	50	0	50	6.2
Passaic	1495	74	1569	196.1
Salem	385	4	389	48.6
Somerset	1149	10	1159	144.8
Sussex	0	0	0	0
Union	947	55	1002	125.2
Warren	153	38	191	23.8
Totals	20825	671	21496	2687.

NUMBER OF CHILDREN REPORTED AS RECEIVING FREE STATE
BIOLOGICALS SINCE JULY 1, 1938

DIPHTHERIA TOXOID

SMALLPOX VACCINE

County	Total to March 31	Month of April	Total to April 30	Average per Month
Atlantic	728	32	760	76.
Bergen	2393	265	2758	275.8
Burlington	473	5	478	47.8
Camden	1354	46	1400	140.
Cape May	375	0	375	37.5
Cumberland	97	97	194	19.4
Essex	8709	1131	9840	984.
Gloucester	270	298	568	56.8
Hudson	3697	559	4256	425.6
Hunterdon	139	146	285	28.5
Mercer	2497	40	2537	253.7
Middlesex	989	10	999	99.9
Monmouth	313	11	324	32.4
Morris	454	109	563	56.3
Ocean	202	0	202	20.2
Passaic	2368	193	2561	256.1
Salem	274	17	291	29.1
Somerset	138	3	141	14.1
Sussex	5	0	5	.5
Union	1223	162	1385	138.5
Warren	422	9	431	43.1
Totals	27120	3233	30353	3035.3

County	Total to March 31	Month of April	Total to April 30	Average per Month
Atlantic	519	20	539	53.9
Bergen	1802	184	1986	198.6
Burlington	251	9	260	26.
Camden	2236	8	2244	224.4
Cape May	347	0	347	34.7
Cumberland	210	13	223	22.3
Essex	3905	260	4165	416.5
Gloucester	410	23	433	43.3
Hudson	2913	47	2960	296.
Hunterdon	17	1	18	1.8
Mercer	991	47	1038	103.8
Middlesex	1731	17	1748	174.8
Monmouth	1050	28	1078	107.8
Morris	754	74	828	82.8
Ocean	50	0	50	5.
Passaic	1569	101	1670	167.
Salem	389	13	402	40.2
Somerset	1159	13	1172	117.2
Sussex	0	0	0	0.
Union	1002	119	1121	112.1
Warren	191	4	195	19.5
Totals	21496	981	22477	2247.7

BOOKS RECEIVED FOR REVIEW

Mechanism of Thought, Imagery, and Hallucination, by Joshua Rosett, Professor of Neurology, Columbia University. Price \$3.00. 289 pp. illus. N. Y. Columbia University Press.

Anatomy of the Human Lymphatic System, by H. Rouvière. A compendium translated from the original by M. J. Tobias. Price \$4.00. Pp. 318. Ann Arbor, Michigan, Edwards Bros.

Physicians and Medical Care, by Esther Lucile Brown. Price \$.75. Pp. 202. N. Y., Russell Sage Foundation.

Chronic Diseases of the Abdomen; a Diagnostic System, by C. Jennings Marshall. Price \$6.00; pp. 247. Boston, Little Brown Co. 1939.

Portrait Catalog. Fifth International Congress of Radiology. Palmer House, Chicago, 1937.

Life and Letters of Fielding H. Garrison, by Solomon R. Kagan. With an introduction by Prof. James J. Walsh. Price \$3.00; pp. 287. Boston, Medico-Historical Press. 1938.

Textbook of Bacteriology, by Hans A. Zinsser. 7th ed. Price \$8.00; pp. 1255, illustrated. N. Y., Appleton-Century.

English, German, French, Italian and Spanish Medical Vocabulary and Phrases, by Joseph S. F. Marie. Price \$3.00; pp. 353. Philadelphia, Blakiston's Son & Co.

WORDS AND MUSIC, by Halvor Larson Harley, M.D., Atlantic City, N. J. Published by the author, 1938.

This is a volume of eighty-one pages of short verses on various topics, descriptive and sentimental, and often inspired largely by the varying moods of the ocean shore, as for example:

"Great quietness from out of the deep
Gave quietness to me,
A gift it was not mine to keep,
So treacherous the sea.
Now for that victory I weep,—
That almost seemed to be."

DUST OF OUR TIME, by H. Ameroy Hartwell, M.D., Weehawken, N. J. Published by the author.

This small volume consists of eighty-one pages, and contains many striking bits of philosophical verse. Physicians will find the volume a source for quotations illustrating their pensive moods, such as the following:

"When mortal mind at last shall comprehend
The human values that alone endure;
When rich and poor combine, and right defend,
Our faith and peace in life shall be secure.
Eternal force lies in the hand of right,
And all things fragile crumble through its might."

WHAT'S WRONG WITH ME?, by H. Ameroy Hartwell, M.D., Weehawken, N. J.

The object of this volume, as set forth in the preface, is to enable the lay reader to discover the beginning of what might become a serious disease by observing the symptoms of illness while they are in a curable stage. It is intended to direct the patient to his family doctor to secure relief from his symptoms. It is arranged in the alphabetical order of diseases, beginning with *acne*, and ending with *yellow fever*.

MEDICINE AND DENTISTRY MUST BE RE-BORN. By W. G. Hayden, M.D., Toms River, N. J. 90 pages. Published privately. Price \$1.00.

This small volume is written by a New Jersey physician who is a Past President of the Ocean County Medical Society. The author announces on its title page that it is "A satire on the two professions" of medicine and dentistry. Like other satirists, he dwells on the imperfections of medical practice, but he gives figures to prove his points. He also suggests a "New system of rendering and charging", which is largely that of the Mayo Clinic applied to a rural community.

In closing, the author suggests that the President of the United States appoint a committee of four

citizens, four office-holders, four physicians, and four dentists, to formulate a national health policy.

CLINICAL GASTRO-ENTEROLOGY. By Horace Wendell Soper, M.D., F.A.C.P., St. Louis, Mo. Published by The C. V. Mosby Co. Price \$6.00.

The volume under review covers the most important disorders of the gastrointestinal tract from mouth to rectum, inclusive. Each chapter begins with a brief description of the subject matter under discussion, including diagnostic and therapeutic suggestions, followed by many excellent photographic x-ray illustrations.

Case reports, dietary tables, and numerous prescriptions from the author's personal experience add value to the text.

Only a few of the more salient chapters can be described for in its 300 pages the book contains a great wealth of material for all those interested in this branch of medicine.

The chapter on the *oral cavity* describes the various forms of stomatitis, with their treatment. However, this reviewer doubts whether neosarsphenamine could be called a specific for granulocytopenia.

Milk is discredited by the author in any form, except evaporated milk; and those who may disagree with him may be interested to learn his reasons. This reviewer cannot agree, however, in the use of this highly sweetened milk in the treatment of peptic ulcer. Likewise, the use of lavage in bleeding ulcers is a rather controversial question.

The chapter on *colon and constipation* is excellent, and therein one may learn how to prepare the doctor's famous palatable agar agar flakes.

The chapters on *colitis*, simple and ulcerative, are rather meager to one who is not familiar with the subject. However, the author has given a few excellent facts relating to these intractable disorders. Indicanuria,—a much neglected subject,—receives an all too brief chapter, but it is worth reading as a guide to a more intensive study.

Proctosigmoidoscopy and ano-rectal disorders are described all too briefly. It would perhaps have been more advisable to have left such a highly specialized subject.

Brief chapters on the liver and gall-bladder, obesity, and food allergy conclude the book.

The typography and illustrations are excellent. The book will be found useful to those who wish to use it as a quick reference on therapeutics. It is also of value as a guide to the roentgen ray interpretation of organic gastrointestinal lesions.

J. GERENDASY.

MEDICINE IN MODERN SOCIETY. By David Riesman. Pp. 226. Price \$2.50. Princeton, N. J., Princeton University, 1938.

One observes that the author is, lock, stock and barrel, in favor of so-called *socialized medicine*. Even though he freely admits the wonderful work of the American Medical Association, he is so biased in his efforts to maintain his beliefs that he fails to concede that this same association is capable of assuming the leadership in

this expert field of service to the nation. It would have been far more consistent if he came out in favor of group-medically-controlled and directed service to the nation, for which the profession now stands and fights on an altruistic basis. To take his own argument—why not let the Mayo Clinic, or a similar organization, run the Medical Service of the country with a free hand, under a minimum of joint executive and congressional supervision?

As far as the historical part of this book is concerned, one must bestow praise on the author, for it certainly helps to give the layman, and even the doctor, a fine orientation of the progress of medicine. It does seem strange that all this remarkable progress has come about without any extra-professional supervision or regimentation.

To the reviewer it would seem that the book suffers from its advocacy of "An inevitable movement of reform", of which none of us are any too sure. The book is written for the laity, and contains an implied invitation for medical administration, because of the *laissez-faire* and destructive criticism of the organized profession.

The concluding sentence of the last paragraph of Chapter XIV is a most cogent argument in favor of the absolute control and direction of the nation's health by the medical profession. He admits that, "If it fails to lead, it will be obliged to follow those who have neither the knowledge, the wisdom nor the incentive to preserve what is best in American Medicine!"

C. C. BELING.

PHYSICIANS AND MEDICAL CARE. By Esther Lucile Brown of the Department of Statistics, Russell Sage Foundation. Price, \$.75. Pp. 202. N. Y. Russell Sage Foundation, 1937.

This book is of interest to every physician, especially the young physician who is anxious to get first-hand statistical knowledge regarding the economic trend in the practice of medicine. It deals with medical practice as it has developed under government and industrial direction, and discusses the cost of medical care. It concludes with a statement of the great difficulty of artfully fashioning an apparatus to work in such a way that all people may receive medical care.

C. C. BELING, M.D.

THE VAGINAL DIAPHRAGM; ITS FITTING AND USE IN CONTRACEPTIVE TECHNIQUE. By Le Mon Clark, M.S., M.D. Price, \$2.00. Pp. 107; illustrated. St. Louis, C. V. Mosby Co., 1939.

This little monograph describes the contraceptive technic which in the experience of numerous large birth control clinics has been found most reliable. The method advocated is presented in minute detail. The text is clear and concise, and is supplemented by numerous photographs and diagrams which accurately illustrate each step in the technic. The book fills a long-felt need and should prove invaluable to physicians interested in this branch of gynecologic practice.

ROYAL A. SCHAAF, M.D.

OUTLINE OF ROENTGEN DIAGNOSIS: AN ORIENTATION IN THE BASIC PRINCIPLES OF DIAGNOSIS BY THE ROENTGEN METHOD. By Leo G. Rigler, B.S., M.B., M.D., Professor of Radiology, University of Minnesota, Minneapolis. Atlas Edition. Cloth. Price, \$6.50. 212 pp. with 254 illus. shown in 227 figures, presented in drawings and reproductions of roentgenograms. Figures 6 to 51 and 55 to 72 are drawings in an original technic by Jean E. Hirsch. Students 8 ed. (exclusive of atlas), paper, price \$3.00. Philadelphia, Lippincott, 1938.

There is an Atlas Edition of 254 illustrations shown in 227 figures, presented in drawing and reproduction of roentgenograms. Figures 6 to 51 and 55 to 72 are drawings in an original technic by Jean E. Hirsch. Price \$6.00. A paper-bound edition without illustrations is also published, price \$3.00. J. B. Lippincott Company, New York.

Before buying this book, one should read the preface, for the author clearly states the purpose of the book and the reasons which prompted him to write it. As a teacher of radiology, he found it convenient "to prepare a series of lecture notes in mimeograph form. These notes, revised and expanded, have been used as a supplement to didactic lectures to undergraduates, as a text in teaching extension courses to general practitioners, as a study outline for graduate students and, by radiologists, as a synopsis for lectures."

He also states that the book is in no sense a reference book, and little attempt has been made to detail the more uncommon conditions or to elaborate upon the rarer manifestations of common diseases. He feels, and rightly so, that no scientifically trained individual will attempt to employ so potent a weapon as the roentgen rays without acquainting himself thoroughly with its physical basis, its method of application, and the serious risks involved. Therefore, no effort is made to present these aspects of radiology. Instead an outline is given in

a systematic manner of the indications, possibilities, and limitations of the roentgen method of diagnosis.

It, therefore, becomes apparent that this book will best be used by students, teachers, and general practitioners. Here it should prove particularly useful.

The contents are divided into eleven sections,—each section except two pertaining to some part of the body, and one each to general principles of roentgen diagnosis and miscellaneous. The first section is well worth reading, as the uses of roentgen diagnosis are briefly but well stated. The part on definition of terms seems particularly pertinent.

The subject matter is well arranged so that one can quickly find the particular point in question. The index appears to be comprehensive and accurate. Many of the illustrations are drawings made of roentgenograms so that the part desired to be shown can be stressed. All cuts are negatives, so that the whites and blacks appear as in the original roentgenogram. This is particularly pleasing. This book would seem to be a well-worth-while investment for all students, general practitioners, and others interested in any phase of radiology.

OUR COMMON AILMENT—CONSTIPATION: ITS CAUSE AND CURE. By Harold Aaron, M.D., Medical Consultant to Consumers Union of U. S., Inc. A Consumers Union publication. Published by Dodge Publishing Company, New York. Price \$1.50.

This is a book of valuable propaganda for public consumption, since it mentions by name many of the commonly advertised laxative medications and subjects them to tests for comparative value. It will be of interest to doctors, and a money-saver for sufferers of constipation who buy proprietary medications; but it can hardly be recommended to take the place of the advice of the family doctor.

CONTACTS AND COMMENTS

COME TO THE ANNUAL MEETING

It is an old saying that you can "Lead a horse to water, but you cannot make him drink". But if you come to the annual meeting you cannot fail to absorb its impressions and its inspiration.

The day of medical individualism has passed; and every physician must join hands with his colleagues in order to conserve his own private interests.

You cannot afford to forego the benefits which you will derive from the annual meeting. The demand of a seriously sick patient is your only legitimate excuse for staying at home.

SUPPLEMENTARY LIST OF MEMBERS

It has been planned that from time to time the Society should publish a list of members who had been elected or re-instated since the publication of the Official List as a supplement to the April Journal.

Only one error in the Official List has been reported—that of Dr. William S. Serri, of Mullica Hill, Gloucester County. His name appeared on the typed copy of the list among those who had paid their dues for the year, but was omitted because it had become blurred as if it had been erased intentionally. The error was discovered when a final checking of

the lists and accounts was made. The missed numbers of The Journal will be sent to Dr. Serri, and all the other benefits of his membership will be continued.

MEDICAL LIBRARY ASSOCIATION

The *Medical Library Association* will hold its next annual convention in Newark on June 27-29, as the guests of the Academy of Medicine of Northern New Jersey. This association was founded in 1898 in Philadelphia, with Dr. George M. Gould as one of the prime promoters. Its membership comprises medical and dental libraries, librarians, and doctors.

Among the subjects of special interest to physicians are:

At 1 p. m., June 26—

Why Medical History for Medical Librarians—Dr. George H. Lathrope, Morristown.

The Hospital Library—Miss Marguerite Prime, American College of Surgeons Library.

At 8 p. m.—

Medical Stamps, illustrated—Miss Margaret Bates, University of Illinois Library.

Wednesday, 2 p. m.—

Problems in Microphotography.

At 7 p. m.—

Annual Banquet, in the Hotel Douglas, with addresses on the Airplane in Medicine by Dr. Charles H. Young, Montclair.

Spectacular Flights—Captain Arthur Coperton, American Air Lines.

Physicians are invited, especially those who are editors or authors.

MILDRED V. NAYLOR, *Librarian*,
The Academy of Medicine.

TUBERCULOSIS LEAGUE

The Spring Conference of the New Jersey Tuberculosis League will be held on Friday, June 2, 1939, in the Berkeley-Carteret, Asbury Park, N. J. Sessions will be held in the morning and the afternoon, with a luncheon session at 12:30 o'clock. Twenty-five speakers are listed of whom eleven are physicians, as follows:

Leavett D. Bristol, Newark
M. J. Fine, Newark
A. E. Jaffin, Jersey City
Elliot I. Dorn, Glen Gardner
Martin H. Collier, Camden
Allen G. Ireland, Trenton
Charles I. Silk, Perth Amboy
Byron M. Harman, Verona
Marcus W. Newcomb, Brown's Mills
Homer H. Cherry, Paterson
B. S. Pollak, Jersey City

The three principal subjects to be presented are:

Case-finding in clinics

Mass surveys

Employment of ex-patients

Physicians are invited to attend the sessions.

A. M. A. MEETING

The full delegation of New Jersey representatives attended the Annual Meeting of the American Medical Association, which was held in St. Louis on May 15-19. Since the June Journal goes to press while the meeting is still in progress, a report of the meeting is impossible; but the Delegates will doubtless make a report to the Annual Meeting on June sixth.

EXHIBITS AT THE A. M. A.

Mrs. Ily R. Beir, Chairman of the Art and Historical Exhibit of the Woman's Auxiliary, is also chairman of a similar committee of the A. M. A., as she also was last year when she arranged a record-breaking show of historical material in which the New Jersey exhibit was outstanding (*Jour.*, April, p. 253). This year the New Jersey exhibit at the A. M. A. is still larger.

EDUCATIONAL REQUIREMENTS FOR PUBLIC HEALTH POSITIONS

The American Public Health Association has recently issued leaflets dealing with the educational requirements which a candidate should meet in order to have charge of the supervision and management in any of the following lines of work:

1. Statisticians.
2. School Health Educators.
3. Public Health Engineers.
4. Sanitarians.
5. Sub-professional Field Personnel in Sanitation.

Each report is issued free of charge for the purpose of raising the educational standards of professional public health personnel. Copies may be secured from the Book Service, American Public Health Association, 50 West 50th Street, New York, N. Y., Reginald M. Atwater, Executive Secretary.

A CORRECTION

A regrettable error was made in the arrangement of the cuts of the excellent article on obstructed ureter in the April Journal. The legend of the second cut on page 219 should have read, "Fig. 4, Case 2", while that of the cut on page 230 should have read "Fig. 3, Case 2".

We offer our sincere apology to the author and to our readers.

RABIES IN BERGEN COUNTY

The outbreak of rabies in Bergen County continues, but with fewer cases developing. The quarantine of all dogs is still in force, but it is probable that the new reported cases received their infection before the quarantine was imposed.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

MAY, 1939

2 Camden (Annual Meeting)	11 Essex (Annual Meeting)
2 Hudson (Annual Meeting)	11 Passaic (Annual Meeting)
9 Bergen (Annual Meeting)	12 Atlantic (Annual Meeting)
9 Sussex (Annual Meeting)	12 Salem (Social Meeting)
10 Mercer	17 Middlesex
10 Ocean (Annual Meeting)	18 Gloucester (Annual Meeting)
10 Union	18 Morris
11 Burlington	24 Monmouth

JUNE, 1939

8 Somerset (Annual Meeting)	15 Morris (Annual Meeting)
13 Bergen	21 Middlesex
13 Cumberland	28 Monmouth
14 Mercer	Camden (Outing Meeting)

JULY, 1939

18 Warren (Annual Meeting)	28 Hunterdon
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ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held at the Ambassador Hotel on January 13, 1939, with the President, Dr. James H. Mason, presiding, and thirty-eight members and guests present.

SCIENTIFIC

The scientific paper of the evening was on the subject "Plastic and Constructive Surgery", by Dr. Hans May, Instructor in Surgical Pathology at the University of Pennsylvania, and was discussed by Drs. McGivern, Johnson, Roop and deHellebranth.

CARE OF INDIGENTS

Dr. Scanlan for the Public Health Committee recommended that a joint committee composed of a representative of each of the following meet to devise a way to care for the indigent: Atlantic County Medical Society, Overseer of the Poor, Visiting Nurses' Association, City Health Officer, Mayor of Atlantic City.

CANCER STUDY

Dr. Roop, reporting for the Cancer Central Committee, recommended that one meeting be devoted to the study of cancer.

TUBERCULOSIS

The special committee appointed to study tubercular testing of children in high schools made the following recommendations:

1. That only first-year students be tested on account of the cost.
2. That testing be done outside of Atlantic City first.
3. That intensive educational work be done before testing is started.
4. That volunteers for the work be specially trained.
5. That volunteers receive remuneration.

NEW MEMBERS

Dr. Vincent J. Di Nicolantonio, and Dr. Howard S. Hudson, were elected to membership; and one proposal for membership was received.

DISCIPLINE

Dr. Salasin submitted a written report of the action of the Censors in regard to charges against a member of the society.

The regular meeting of the *Atlantic County Medical Society* was held at the Ambassador Hotel February 10, 1939, at 8:30 p. m., with President Mason presiding, and fifty-six members present.

Dr. Allman of the Legislative Committee reported that a new A-511 bill was to be reintroduced in the Legislature and asked the active support of the members of the society.

NURSING HOMES

The applications of Dr. Louis Rodi, of Hammon-ton, and Mrs. Florence Filling, of Pomona, N. J., for permits to conduct nursing homes were approved by the society.

DEBATES

Dr. Shore announced the debates on Socialized Medicine to be held at Mays Landing, N. J.

DISCIPLINE

The case of discipline carried over from the January meeting was decided by the expulsion of the member for one year.

The regular meeting of the *Atlantic County Medical Society* was held at the Ambassador Hotel at 9 p. m., March 10th, 1939, with President James H. Mason presiding, and forty-eight members present.

SCIENTIFIC

The scientific program was the presentation of a paper by Dr. William Herrman, Past President of The Medical Society of New Jersey, on "Cancer Should Be of Interest to the General Practitioner". It was ably discussed by Drs. Roop, Davidson, Carrington, Allman, Scanlan, Brown, and Shivers.

LEGISLATION

Dr. Allman discussed the important features of the new Uniform Medical Practice Act, and asked that all members of the society communicate with our county legislators and express appreciation for their support.

Dr. Reed asked all members to get lay support for the bill.

It was moved by Dr. Hyman and carried that printed postcards be distributed to patients, signed by them, and sent to the legislators.

Dr. Allmen read letters from Assemblymen who promised their support of the bill.

MATERNAL WELFARE

Dr. Quinn reported that the Maternal Welfare Committee did not approve of the set-up of the State Maternal Welfare Committee, and recommended that provision be made by municipalities for obstetrical cases the same way as for all other indigent cases. The report was approved by the society.

The Secretary reported for Dr. Madden of the Venereal Disease Committee that it recommended the appointment of Dr. Hudson to take charge of the clinic at Mays Landing; and also recommended the establishment of a Venereal Disease Clinic at the Somers Point Hospital. These recommendations were approved by the society.

FEDERAL FARM RELIEF PROGRAM

Dr. Mason asked for a conference of all rural members of the society to formulate a schedule of fees for farmers, in coöperation with the Federal Farm Relief Program.

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

A regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital, February 14, 1939. President King being ill, the meeting was in charge of Dr. G. M. Knowles, the Vice-President.

A letter from the Paramus Board of Health concerning the choice of physician when the owner of a rabid dog was paying the expenses of the person bitten by the dog was read. The Paramus authorities were informed that the patient should have the choice of the physician.

A letter from Rutgers University concerning a six-lecture post-graduate course was tabled because our own course, which is being held at the present time, is well attended.

MEMBERSHIPS

Three applications were received for junior membership and three for regular membership.

The following were elected to membership:

R. F. Maddern, Hackensack
S. J. Ross, Allendale

MALPRACTICE INSURANCE

Dr. C. C. Beling, Chairman of the Committee on Medical Defense and Insurance, was introduced and gave an interesting talk on the development of Malpractice Insurance as related to The Medical Society of New Jersey.

Mr. W. P. Braun, Defense Attorney on malpractice cases for The Medical Society of New Jersey, spoke of the relationship between doctor and patient. He gave some of the pitfalls that confront the doctor in these relations and illustrated his talk with cases. Mr. Braun then indicated how these pitfalls may be avoided.

A regular meeting of the *Bergen County Medical Society* was held at Bergen Pines, the county hospital, on March 14, 1939. The members of the Passaic, Hudson, and Rockland County Societies had been invited to this meeting.

Dr. King mentioned the letter from Dr. William J. Carrington, President of The Medical Society of New Jersey, which enclosed the proposed amendment to the Constitution (Jour., Feb., p. 118).

The Executive Secretary announced that the Secretary had a list of osteopaths who had a full license to practice medicine and surgery.

Dr. Alexander explained the progress of the Medical Practice Act now known as Assembly Bill Number 210, and read a favorable editorial appearing in the *Bergen Evening Record*.

Dr. Wright MacMillan of the Passaic County Medical Society spoke and asked for support of the program of the Sterilization League of New Jersey.

SCIENTIFIC

Dr. Joseph Morrow, Superintendent of Bergen Pines, opened the scientific program with a paper on "Twenty Years Treating Communicable Diseases in Bergen Pines".

Dr. Joseph Gordon then spoke on "Non-tuberculous Pulmonary Diseases Admitted to Bergen Pines in the Last Two Years".

Dr. William A. Lell, Associate in Bronchoscopy at the University of Pennsylvania School of Medicine, showed his splendid motion pictures of bronchoscopic work, and explained the pictures as they were being shown.

The regular meeting of the *Bergen County Medical Society* was held in the Englewood Hospital on Tuesday evening, April 11, 1939.

LEGISLATION

The President, Dr. King, reviewed the essential points of Assembly Bill 210, and it was suggested that all members of the society be sent the addresses of our assemblymen and senators, so that letters could be written by the doctors and interested patients.

ELECTIONS TO MEMBERSHIP

To Junior Membership:

A. F. Padden of Hackensack
Max Utens of Westwood
D. A. Gitterman of Englewood
P. J. MacLaren of Westwood

R. W. Kulle of Ridgewood
S. R. Schiro of Ridgefield Park

From Junior to Regular:

W. H. Lemmerz of Woodridge
O. S. Hensle of Hackensack
F. J. Marx of West Englewood
R. C. Schretzman of Rutherford

To Regular Membership:

D. F. Reilly of Paramus
E. W. Richards of Hackensack

PUBLIC HEALTH WEEK

Dr. King made some announcements concerning our Public Health Week to be held from May 14th to May 21st. The week is to be fairly well crowded with hospital exhibits, public health organizations' exhibits, the presentation of the picture "Birth of a Baby", and an open afternoon meeting sponsored by the Woman's Auxiliary, at which Dr. Haven Emerson will be the speaker.

MEDICO-LEGAL COMMITTEE

A new committee called the *Medico-Legal Committee* was appointed by the President. The proposed amendments to the State Constitution were approved.

REPORT OF THE NOMINATING COMMITTEE

For President, G. W. Knowles of Hackensack
For Vice-President, R. K. Tether of Closter
For Secretary, G. B. Barlow of Englewood
For Treasurer, W. K. Harryman of Hackensack
For Reporter, A. T. V. Brennan of Englewood

A vote will be taken on May 9, and those elected will assume office June 13.

For Delegates and Alternates to the State Convention, 1939-1940-1941:

DELEGATES	ALTERNATES
J. R. Morrow	E. T. Seymour
A. Liva	L. A. Hitzman
E. N. Huff	V. A. Blenkle
W. L. Vroom	L. Burnham
G. M. Knowles	W. L. Jordan
G. B. Barlow	W. C. Rucker

SCIENTIFIC

The scientific program was in charge of the Maternal Welfare Committee. The following members of the committee gave short talks on maternal welfare: Dr. Burnham, Dr. Wilson, and Dr. Prather. The speaker of the evening, Dr. E. H. Dennen, spoke on the use of forceps, and illustrated his talk with moving pictures.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the City Dispensary Building on March 7th, 1939, at 9 p. m., with the President, Dr. H. Wesley Jack, presiding, and eighty-nine members and guests present.

SCIENTIFIC

Dr. Thomas M. McMillan, Associate Professor of Cardiology at the Graduate School of Medicine, University of Pennsylvania, gave a very excellent talk on "Rheumatic Fever and Rheumatic Heart Disease".

NEWSPAPER ADVERTISING

Dr. Rogers presented the "Paid Newspaper Advertising" Campaign as outlined by the Public Relations Committee of the State Society. He explained the type and manner of the advertising, and announced that the approximate cost to finance the campaign in its entirety would be approximately \$1,500.00. Dr. Rogers recommended this be done and moved that the recommendation be adopted. The motion was passed.

Dr. West, Chairman of the Maternal Welfare Committee, suggested that the society approve the establishment of a Maternal Death and Stillbirth Conference to be held in the county at regular intervals.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The April meeting of the *Cumberland County Medical Society* was held in the Hotel Cumberland Tuesday afternoon, April 11, 1939. In the absence of Dr. Dare Woodruff, President, Dr. J. F. Reeves, Vice-President, presided. The roll-call showed an unusually large number present.

SCIENTIFIC

The guest speaker was Dr. Henry I. Tumen, of Philadelphia. He discussed "The Management of Duodenal Ulcer".

MATERNAL WELFARE

Dr. Arthur W. Bingham, Chairman State Maternal Welfare Commission, discussed the subject of "Prenatal Care as Related to Maternal Mortality". He showed that Cumberland County had increased its maternal death record by 1.5 per cent and analyzed the causes and the possibilities for preventing them. He asked the reason for the fall in the birth rate, and it was explained that it was due to the propaganda of birth control, and that at the rate of decrease in a few years there would be no need for maternal care.

ELECTION OF OFFICERS

The following officers were elected for the coming year:

President, J. Franklin Reeves
Vice-President, Charles Butcher
Treasurer, H. H. Wilson
Reporter, Mureal E. Ramsay
Censor, Charles E. Gray

Executive Committee—H. G. Miller, H. E. Lore, Mary Bacon
Delegates to the State Society—H. B. Walker, L. J. Kauffman, Helen E. Weithasse

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held at the Academy of Medicine on April 13th, 1939. The meeting was called to order promptly at 9 p. m. by President David A. Kraker.

The program of the meeting was under the auspices of the Child Welfare Committee. A Symposium on Child Care in Essex County was taken as the topic.

The following sub-divisions were discussed by the following physicians:

1. "Care of the New Born", by Dr. Robert Jennings
2. "Pediatric Clinics", by Dr. William Pannitch
3. "School Physicians", by Dr. William Nevius
4. "Immunization", by Dr. David P. Evans
5. "Child Welfare Publicity", by Dr. Harold Murray

The following were all elected:

To full membership:

D'Ambola, Philip B., Harrison
Granberry, D. Webb, Orange
Rossi, Bartolomeo, Belleville (by transfer)

To associate membership:

DuGerome, James, Glen Ridge
Di Gracomo, Harry E., Newark
Kosterlitz, Hans, Irvington
Strauss, Max, Newark
Trasuley, William F., Maplewood

For Delegates to State Society (to fill vacancies for 1939):

Delegates—

R. A. Schaaf, Newark
J. T. English, Newark
B. Saslow, Newark
W. H. Huber, Newark
B. A. O'Connor, Newark
Charles Rich, Newark
Joseph Echikson, Newark
W. H. A. Warner, East Orange

Alternates—

F. P. Willey, Bloomfield
E. Albano, Newark
C. A. Beling, Newark
S. Z. Hawkes, Newark
M. J. Avidan, Newark
M. M. Baker, Irvington
William Grant, Newark
G. F. Hewson, Newark
Lewis Loeser, Newark
Julius Newman, Newark
A. L. Rich, Newark
A. F. DePalma, Newark
Frank Rocco, Newark
E. P. Schaefer, Irvington

GLOUCESTER COUNTY

H. B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Homestead Coffee Shop in Woodbury on Thursday evening, April 20th, at nine o'clock, with twenty-four members present.

DELEGATES TO OTHER COUNTY SOCIETIES

The delegates to the various county societies gave their reports. Dr. Henry B. Diverty, of Woodbury,

told of having attended meetings of the Camden and Burlington County Societies and also spoke of the fine quality and attendance at the post-graduate course in Camden.

Dr. Collins, of Paulsboro, reported having attended the meeting of the Cumberland County Society.

PUBLIC RELATIONS

The Committee on Public Relations reported that it had supplied speakers for two groups since last meeting.

LEGISLATION

The Legislative Committee reported that the Modified Medical Practice Act had passed the Assembly and would come before the Senate this week. It was expected that this bill would pass the Senate.

The Secretary was instructed to write the U. S. Congressman and Senator and give them additional information concerning our opposition to the Wagner Health Act and also some constructive criticism in regards to this bill.

SCIENTIFIC

The Committee on Scientific Program presented Dr. George Geckler, of Philadelphia, who spoke on "Some Features of Coronary Heart Disease".

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, April 4th, 1939, at the Hudson County Tuberculosis Hospital, Jersey City. The meeting was called to order by the President, Dr. Reeve L. Ballinger, at 9:30 p. m.

SCIENTIFIC

Dr. Ballinger: "I would now like to introduce someone who needs no introduction, one of our Past Presidents, Dr. B. S. Pollak, who will introduce the guest speaker of the evening."

Dr. B. S. Pollak: "I am afraid that many of the members of the society have failed to notice the change in environment. Recently at a meeting of the Program Committee of the Hudson County Medical Society, it was decided that we would hold several meetings of the society in the various hospitals, and it is our signal honor to welcome you first. I wish to thank you on behalf of the Board of Managers of the Hudson County Tuberculosis Hospital. The members of the profession are very welcome to come here and take advantage of all the facilities available. We would be glad to entertain you at any time. We have a very beautiful museum and we would like you to take advantage of this. The facilities of this hospital are open to you for your private or semiprivate patients. This is available to you at the present time.

"The tuberculosis problem, as you know, has been stimulated for more than twenty-five or thirty years by the National Tuberculosis Association. The month of April has been set aside for the past quarter of a century for an 'Early Diagnosis Campaign'. I think we are auspiciously starting it by having with us tonight a man whom I have known for

many years and I am very happy to introduce Professor Edgar Mayer of Cornell University Medical College, whose subject will be 'Early Diagnosis in Tuberculosis'."

Dr. Mayer gave his address, which was discussed by Drs. A. E. Jafin, S. Cohen, B. P. Potter, H. J. Perlberg, and R. L. Ballinger.

LEGISLATIVE COMMITTEE

Dr. B. S. Pollak: "I wish to state that the Legislative Committee of The Medical Society of New Jersey is having a very active year, and I feel that the newspapers have probably kept you informed concerning the Medical Practice Bill A-210. The medical men and members of the press have come to a mutual understanding, and the outlook for A-210 is very encouraging."

POST-GRADUATE COMMITTEE

Dr. T. J. White stated that there will be a post-graduate course to be given four Thursdays in May and four Thursdays in June. The subject will be "Pathology", and the teacher will be Dr. Paul Klemperer, one of our outstanding pathologists. Dr. White feels that any physician in the county will be amply rewarded by taking this course. The Secretary's office will mail full particulars pertaining to this course.

NOMINATING COMMITTEE

The following members were elected to serve in 1940 on the Nominating Committee: Dr. A. J. Conty, Dr. E. J. Daly, Dr. W. T. Callery, Dr. J. A. Botti, Dr. C. J. Larkey.

MERCER COUNTY

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on April 12th, 1939, President Walsh presiding.

Four applications for membership were received.

SCIENTIFIC

Dr. Hans May, Philadelphia, spoke on the subject of "Plastic and Reconstruction Surgery of the Body".

Dr. May gave a most interesting account of the beginning of this type of work in the sixth century, and its progress through the succeeding centuries, until at the present time the reconstruction of the maimed, disfigured, and malformed body is declared to be a separate and distinct branch of surgery.

The speaker defined the several types of plastic methods and procedures with emphasis placed upon the circulatory system as a governing factor in the successful accomplishment of reconstructive work.

Many instructive moving pictures were shown.

COMMITTEE REPORTS

Tuberculosis—Dr. Wayman, Chairman of the Tuberculosis Committee, rendered a report of the examination so far done on 1,984 school children, with discussion relative to the results obtained.

Post-Graduate—Dr. Purcell reported that the post-graduate courses are well attended; however,

about ten more members are desired in order that a full quota may be recorded.

Pharmacy—Dr. Zimskind reports that the Mercer County Pharmaceutical Association has expressed a desire for a combined meeting with the Medical Society, plans for which will be made by the combined committees in the near future.

LEGISLATION

Dr. Haggerty expressed the opinion that an earnest effort should be made by the members personally acquainted with our Assemblymen to obtain their support of Bill A-210.

MIDDLESEX COUNTY

Howard Dieker, M.D., Reporter

The regular meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, N. J., on April 19th, 1939. The President, Dr. N. N. Forney, called the meeting to order at 9:20 p. m.

NEW MEMBERS

Dr. Solomon Goldman and Dr. Joseph Smith were elected to full membership.

Dr. Walter Kiefer was elected a regular member on transfer from Somerset County.

Dr. William E. Ramsay, of Perth Amboy, N. J., was elected to an honorary life membership.

UNFINISHED BUSINESS

Dr. Marshall Smith gave a description of the portable dolly to be constructed for use in making teaching films by the Bio-photography Department of Rutgers. A motion was carried that the society donate \$300.00 to the Bio-photograph Department of Rutgers for this purpose.

A motion was carried that the President appoint a committee to secure a new meeting place. Dr. Marshall Smith, Dr. Slobodien, and Dr. Merrill were appointed to this committee.

NEW BUSINESS

A communication was received from the State Society advising us that we were entitled to appoint one more delegate and one more alternate to the State Society. Dr. Faulkingham was elected delegate, and Dr. Joseph Mark, alternate.

A communication from the State Executive Committee, advising us to support Assembly Bill A-210, was referred to the Legislative Committee.

The President appointed a committee consisting of Drs. Uhr, Degenhart, and Kleiber to study the question of whether or not we should have a post-graduate course this year.

A letter was received from Dr. Carrington advising us of the proposed changes in the State Constitution.

A letter was received from Dr. Rowland thanking the society for supporting his appointment to the State Board of Medical Examiners.

The President appointed a committee consisting of Dr. Mark and Dr. F. M. Hoffman to communicate with the Committee for the Celebration of the President's Birthday, and to advise this committee of the best ways of using its funds.

A letter from Dr. Kler in reference to a paid

newspaper program to acquaint the public with the aims and philosophy of organized medicine will be published in the next bulletin.

At the request of Dr. Overton, the President appointed Dr. Spencer and Dr. McKiernan as a committee to confer with Dr. Overton, to ascertain information about the history of the county society, and to consider an exhibit for the county society at the State meeting.

It was moved that the report of the Committee for the Study of Medical Needs and Supplies of the County be published by Miss Kidd.

A communication was received from the Passaic Medical Society enlisting our support for Dr. Elias Marsh, a candidate for the Second Vice-Presidency of the State Society. It was moved and carried that this communication be tabled.

The President appointed a committee consisting of Drs. Merrill, Fischkoff, Downing, Dieker, and Grieve to study the question of whether or not the society should participate in the State Maternal Welfare program.

The meeting adjourned at 11:30 p.m.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

The annual meeting and election of officers of the *Monmouth County Medical Society* was held on Wednesday evening, April 26, 1939, at the Squankum Inn in Farmingdale.

Dr. Frank Altschul was awarded the door prize, which was in the nature of a Baumanometer.

There was an unusually large attendance at this affair, largely we have had in many years.

ELECTION OF OFFICERS

The following officers were elected:

President, Dr. Robert Mackenzie, Asbury Park
President-Elect, Dr. D. Featherston, Asbury Park

Secretary-Treasurer, Dr. Fred Jamison, Bradley Beach

Assistant Secretary-Treasurer, Dr. George McDonnell, Freehold

Reporter, Dr. Samuel Edelson, Asbury Park

Members of Executive Committee:

Dr. Baeseman, Asbury Park

Dr. Granville Jones, State Hospital, Marlboro

Dr. J. Berkeley Gordon, State Hospital, Marlboro

Dr. Emerson Haines, Asbury Park

Nominating Delegates:

Dr. Byron Blaisdell, Long Branch

Alternate:

Dr. Carlos Pons, Asbury Park

ADDRESSES

Following the dinner and election of officers, the society was addressed by Judge Henry C. Ackerson, State Assemblyman Harold McDermott and Mr. Stanley Herbert, and Dr. William Herrman, of Asbury Park.

Dr. Byron Blaisdell summed up the activities of his presidency in a final address.

EXECUTIVE COMMITTEE REPORT

A meeting of the Executive Committee of the Monmouth County Medical Society was held on Monday evening, April 10th, at the Fitkin Memorial Hospital, Neptune, N. J. The meeting was called to order by President-Elect Dr. Robert MacKenzie at 9:00 p.m.

In response to the request of President Dr. Byron Blaisdell, several committee chairmen have submitted a report on the activities of their committee for the fiscal year 1938-39. These reports were read and ordered published in the Anniversary Bulletin.

RECOGNITION OF CIVIL SERVICES

Dr. William Carrington, President of The Medical Society of New Jersey, has requested the names of any members of our society who during the current year have received some mark of distinction in civic life, such as an election to a prominent public office, or award for personal achievement in the arts, sciences, industry or other fields. If we have any such distinguished members, it is suggested that the names be sent to the Executive Offices in Trenton.

DUES

The Secretary was instructed to again communicate with the delinquent members and advise them that unless their 1939 dues are paid by May 1st, they will be dropped from the society. We regret to state that there are some members on this list.

OCEAN COUNTY

J. Bruce Henriksen, M.D., Reporter

The regular meeting of the *Ocean County Medical Society* was held at the Hollywood Inn at Toms River, N. J., on the evening of April 12th, 1939. President Emanuel Sickel presided and the following members were present: Drs. Bunnell, Bierach, Garmona, Dodd, Gaumer, Goldstein, Halbach, Hayden, Herbener, Henriksen, Ivory, Menge, Obert, Sickel, Szold, Taylor, Towbin, and Witte.

SCIENTIFIC

After an excellent dinner the regular order of business was disposed with and the meeting was turned over to the scientific program. Dr. Bingham, Chairman of the Maternal Welfare Committee of the New Jersey Medical Society, gave an illuminating talk on the maternal welfare conditions in the various counties of our State. He outlined a plan to provide better pre-natal care for the indigent by having them referred to various physicians by our Field Physician, Dr. George Gaumer, who spoke on the practical working of the plan.

Dr. Ellson was next on the program and gave a much appreciated talk upon the management of *bleeding peptic ulcer*. He stressed the importance of deciding whether the case was to be handled medically or surgically at the beginning, and then sticking to the plan which seemed to give the patient the best chance. He surveyed statistics of various plans of treatment, including forced feeding during the bleeding stage. He next spoke of the method of intestinal drainage by the Abbott

tube, and illustrated its use by means of x-ray films.

COMMITTEE REPORTS

The Treasurer reported a number of outstanding bills, and a balance in the treasury of \$457.50. He reported that there was a surplus on hand from receipts obtained at the Ladies' Night Banquet, but the exact amount was not certain because of certain outstanding bills connected therewith.

PRE-NATAL

Dr. Gaumer reported upon activities of the Maternal Welfare Committee, and stressed the importance of educating the husbands of pregnant women to the necessity of pre-natal care.

COMPLAINT INVESTIGATED

Dr. Bunnell reported the coöperation which his committee had received from the Medical Practice Committee of the State Society in investigating charges brought against one of our members by a patient. He further reported that our member in question had been fully exonerated by both committees.

X-RAYS OF CHESTS

Dr. Herbener reported the activities of the Public Relations Committee in which an effort was being made to provide x-ray facilities to take chest pictures at a reduced rate for school children with positive tuberculin reactions. The feasibility of such a program was discussed from different angles by Drs. Sickel and Towbin.

VENEREAL DISEASE

Dr. Witte reported the activity of the Venereal Disease Clinic at Point Pleasant, and stated that three patients were under treatment and that the clinic had functioned for three months.

COMMUNICATIONS

The following communications were read and by action of the society were received and placed on file:

1. American Medical Association,—Royal Pines Hospital.
2. New Jersey State Board of Medical Examiners,—Lakewood Inhalatorium.
3. Medical Society of New Jersey,—Various Legislative Bulletins.
4. Dr. Wilkes,—Members who have acquired some special mark of distinction during the year.
5. Woman's Auxillary of The Medical Society of New Jersey,—Applications for exhibit in Art, Hobby at the State Society meeting.

MEDICAL ADVERTISING CAMPAIGN

Dr. Henriksen opened the discussion of the feasibility of undertaking a medical advertising campaign inasmuch as our treasury was in an apparent healthy state. It was moved by Dr. Towbin and seconded by Dr. Goldstein and carried that action upon this matter be tabled until the next meeting.

EDUCATING DOCTORS ON SOCIALIZED MEDICINE

Dr. Towbin suggested that we educate ourselves upon the various angles of "Socialized Medicine" before we try to educate the public. Dr. Taylor moved, Dr. Menge seconded that we obtain a speaker to address us upon Socialized Medicine at a time and place to be selected by our President.

DEPENDENT CHILDREN

Dr. Taylor reported a communication from the State Board of Children's Guardians which proposed to set up a fee bill for the treatment of its wards in Ocean County. The fee bill suggested was \$1.00 per office visit and \$2.00 per home call. No fee was fixed for tonsillectomy or surgical operations. The matter was discussed, and upon motion of Dr. Halbach, was referred to the Committee on Medical Economics.

PRE-NATAL CARE OF INDIGENTS

Dr. Gaumer moved and Dr. Goldstein seconded that the Ocean County Medical Society endorse the plan of the Maternal Welfare Committee to provide adequate pre-natal care for indigents. Motion carried.

MEETINGS OF THE SOCIETY

Dr. Towbin proposed the following amendment to our By-Laws: Chapter 5, Section 1, shall read: "The meetings of this Society shall be held on the evening of the second Wednesday in each month except July and August", instead of "except June, July, August, and September". The proposed amendment was seconded by Dr. Witte and its first reading was carried out.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held Thursday, April 13, 1939, at the Woman's Club, Paterson. President L. G. Shapiro presided.

MEMBERSHIP

The following new members were elected:

To Active Membership—

Dr. John J. Halnan, Jr., Paterson
Dr. Cosmo Riccobono, Paterson
Dr. Stephen Liana, Passaic

To Associate Membership—

Dr. Frank Becker, Hawthorne
Dr. Marguerite Schafer, Hawthorne
Dr. Ernest Stark, Clifton

Six applications for active members and six applications for associate members were received to be voted on at the next meeting.

PHYSICIANS' RELIEF

The by-laws of the Physicians' Relief Fund of the Passaic County Medical Society were approved, and this fund has been started by the deposit of one dollar for each member.

HOSPITAL PLAN

The Associated Hospital Plan was endorsed by the Society, and a committee will be appointed to further this plan to the public.

LEGISLATION

Assembly Bill No. 210 was then discussed and Dr. McBride emphasized that letters to the Legislators by those who had not yet written would not be too late. He also emphasized the personal appearance of the doctors at the Assembly meeting Monday evening, April 17th.

NEWSPAPER ADVERTISING

The society went on record as approving the paid newspaper advertising plan as suggested by the State Public Relations Committee. One thousand dollars is to be spent on this campaign in the three newspapers of the county.

MILITARY PREPAREDNESS

Lieutenant Colonel Hulett, East Orange, then addressed the society on "Adequate Medical Military Preparedness". He made a plea for greater interest in military affairs by the medical profession. He said that in case of a war emergency that only 30 per cent of the necessary medical staff would be available.

He pointed out that we need more doctors trained for military emergency. He asked the older men to show their advocacy of this action; and the younger men to join the Medical Reserve Corp for added instruction, the association with other physicians, and for their relation to national defense and preparedness.

SCIENTIFIC

Dr. Charles A. Flood, Assistant Dean and Secretary, Columbia University College of Physicians and Surgeons, and Assistant Physician, Presbyterian Hospital, New York City, spoke on "The Results of Medical Care in the Treatment of Peptic Ulcer".

Dr. Flood presented a series of cases which have been followed at the Presbyterian Hospital for the past ten years. The results in the mild cases with medical care were excellent. Those with severe symptoms were treated surgically and their follow-up results were very good. He deplored the use of various injections for ulcers, pointing out that many of the apparent cures were due to a suggestive element. Nervous conditions, strain, and worry were many times the preceding cause of flare-ups in the symptoms of peptic ulcer.

Mr. William P. Braun, Attorney and Counsellor-at-Law, spoke on "The Physician and Malpractice Claims". He brought out the following points for the profession to avoid malpractice suits:

1. Keep accurate and complete records.
2. Do not restrict any laboratory procedures when they are necessary, even though the patient cannot afford them. Arrange with some charitable institution to do the work if it is necessary.
3. Be careful in relations with children or married women. The consent of the guardian, parent, or husband is necessary in any procedure.
4. Do not hesitate to share the responsibility in any case with a consultant; and if he is a specialist, he may even assume the full responsibility.
5. Be frank with the patient or family.
6. Be careful of new methods. Do not experiment on your patients until any new method has

been thoroughly tested and approved by the profession.

7. The indiscreet practice of the profession in their remarks to patients are the cause of 90 per cent of malpractice cases. Any criticism which may reflect on another physician's care of a case may be the starting point of a malpractice suit.

Many questions were answered by Mr. Braun.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The *Salem County Medical Society* held its annual shad dinner on Thursday, May 4, in the Salem Country Club, overlooking the broad expanse of the Delaware River. About thirty members and their wives were present. The fish were broiled, planked style, on the fireplace of the assembly room, and were served at 1:30 p.m.

The only address was a travelogue by Dr. Robert E. Rose, Chief Chemist and Director of the DuPont Technical Laboratory at Carney's Point, near Salem. He was introduced by Dr. William T. Hilliard, of Salem, who described the wide experience of Dr. Rose as a student and traveler, and also the nature of the work which Dr. Rose does in the chemical works. Dr. Rose told about an automobile trip which he made through Albania, describing the difficulties of travel, the primitive life of the people, and the desolate condition of the country because of its mountains.

SOMERSET COUNTY

Hayward F. Day, M.D., Reporter

State Society President Dr. William J. Carrington addressed the *Somerset County Medical Society* at its regular meeting on April 13, at the Somerset Hospital. Dr. Carrington discussed the survey of medical care, Senator Wagner's health bill, and the New Jersey Assembly Bill 210 regulating medical care. He also called attention to the valuable work which may be done by the Auxiliaries along public relations and historical lines.

PUBLICITY

Plans were instituted to run a series of State Society articles in the county newspapers regarding medical problems.

CONSTITUTION

The Committee on Constitution reported that a new constitution is being written to fit the new organization of committees.

MOVING PICTURES

A talking motion picture was presented by Drs. Ely and McConaughy on the care of tuberculosis.

NEW MEMBERS

Drs. Allegrante, Haffner, and Ambrose were elected to membership in the society.

The meeting adjourned at 11:45, and refreshments were served by the nurses of the hospital.

SUSSEX COUNTY

E. K. Hawke, M.D., Reporter

A called meeting of the *Sussex County Medical Society* was held at the Sparta Inn, Sparta, N. J., on April 7, 1939, at 7:30 p. m. Dinner was enjoyed by the fifteen members present and their three guests, Dr. Karl Scott, State Board of Health Department of Venereal Disease Control; Mr. Harry Nicholas, District Health Officer of Sussex, Warren and Morris Counties, and Dr. Soda, Resident of Newton Memorial Hospital.

VENEREAL DISEASE

Following the dinner Dr. Scott outlined the suggestion of a Venereal Disease Control Board for rural counties. One physician, approved by the county medical society, will act as a cooperating physician with the State Department of Health in each of five or six strategically located communities, and will receive a fee of \$100 annually from the State, for which he would agree to give treatments for syphilis to such indigent or medically indigent patients who may be sent to him. These treatments, including examinations, need not exceed 200 annually. In addition, for each treatment, he would be paid by the local board of health having jurisdiction over the residence of the patient an additional 50 cents per treatment. The State will pay the 50-cent charge in the case of transients, and in all cases will supply the drugs and equipment needed.

Mr. Nicholas gave helpful suggestions regarding the arrangements to be made with the local Boards of Health in this plan. After considerable discussion, the county society voted to adopt this arrangement for one year as an experiment.

MATERNAL WELFARE

Dr. Aitken, Field Physician, discussed the Maternal Welfare program, whereby indigent cases would be referred to the Field Physician, and assigned by him to local physicians agreeing to give free prenatal care. He stated that most of the physicians in the county were willing to do this work. After considerable discussion, it was felt that much of the benefit of prenatal care would be lost if a patient went to another physician for delivery, especially in the absence of hospital facilities for indigent cases. The plan was approved with the amendment that the same physician be responsible also for the delivery and the post-partum care of the patient.

Dr. Aitken also outlined again the State-supplied consultant service and nursing care for indigent obstetrical cases.

Thus, although hindered by the absence of hospital clinics, we are attempting, with the aid of the State Society and the Board of Health, to solve our problems of indigent obstetrical and luetic cases.

GRADUATE LECTURES

It was moved and passed by the society to have a series of post-graduate lectures given as soon as a course could be planned under the Rutgers Extension Service.

TUBERCULOSIS TESTING

The society approved of the x-ray clinics being given in the Newton and Franklin Schools under the supervision of Dr. Dorn of the State Tuberculosis League and Miss Warren of the County League.

STATE CONSTITUTION

The society voted its approval of the changes to the State Constitution regarding appeals to the Council and the election of Councilors, as recorded on page 118 of the February Journal.

THE NEW BULLETIN

The Volume One Number One Bulletin of the Sussex County Medical Society made its appearance and was voted a success. An issue is to precede each meeting of the society. The Secretary, Dr. Jesse McCall, is to be the editor.

The next meeting is to be at the Walkill Country Club, Franklin, on May 19th, for the election of officers.

The meeting was adjourned at midnight.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

The shortest annual meeting that has been held in the past five years by the *Union County Medical Society* was called to order by the President, Dr. Henri Abel, on April 12, 1939, at 9 o'clock, at the Muhlenberg Hospital, Plainfield, and was adjourned by the new President, Dr. Rowland Blythe at 10:20. The brevity of this meeting may be attributed to the excellent functioning of the Executive Committee, who brought in satisfactory resolutions to cover several controversial points.

A resolution by the Passaic County Medical Society for endorsement of Dr. Elias J. Marsh as Vice-President of the State Medical Society was read. It was voted that the members of our State Nominating Committee be instructed to vote for Dr. Marsh.

DUES

Dr. Alden R. Hoover, who was elected for his fifteenth consecutive year as Treasurer of the county society, read his budget for the forthcoming year. It was adopted. It was very satisfactory to note that practically 95 per cent of the doctors in the county have paid-up memberships.

BY-LAWS

As the Public Health and Relations Committee, which has been headed for the past five years by Dr. Norman Burditt, felt that its functions were too many and that there was too much power delegated to this important committee, it was decided to divide it into three separate committees, one for public health, one for public relations, and one for legislation, in order to facilitate the carrying out of this part of the county's affairs. This necessitated a change in the by-laws, and as it was the second reading, it was adopted for the ensuing year.

ELECTION OF OFFICERS

The Nominating Committee then presented the ballot for officers, committeemen, and delegates for the coming year. On Dr. Watson B. Morris' motion, the following nominees were elected:

President, Rowland Blythe
Vice-President, George Knauer
Secretary, Lorrimer Armstrong
Treasurer, Alden R. Hoover
Reporter, C. C. Carpenter

Trustees:

Watson B. Morris... '41 Elmer P. Weigel ... '42

Board of Censors:

Jacob Reiner '43 Edward S. Krans ... '44

Finance Committee:

Alden R. Hoover... '41 William Boozean ... '42

Scientific and Literary Committee:

Walter Phelan Paul Kreutz
Edward Callahan

Medical Service Bureau:

George Stein '41 Thomas Walsh '42
Joseph Lepree '41 Lorrimer Armstrong '42
Joseph Butenas '42

State Nominating Committee: H. V. Hubbard; alternate, H. S. Murphy

Delegates (terms expire 1941):

E. S. Krans C. C. Carpenter
T. J. Walsh F. W. Lathrop
R. P. Blythe H. S. Murphy
L. Armstrong E. Stein

Alternates (terms expire 1941):

J. E. Runnells L. S. Wegryn
R. Cantini H. Bloch
L. G. Belsler E. J. Bourns
J. J. Labow F. Warncke

Delegates to State Society (terms expire 1942):

J. B. Harrison C. H. Schlichter
E. P. Weigel W. E. Boozean
H. V. Hubbard I. Gelber

Alternates (terms expire 1942):

L. H. Leggett R. Holland
R. Peters A. R. Casilli
S. H. Davis J. D. Tidaback

In the event of the adoption of by-law now before the society separating Public Health and Relations Committee into three committees—Public Health, Public Relations, and Legislative Committees—the following nominations for each of these committees are submitted:

Public Health Committee:

H. P. Dengler '41 Frances Arthur ... '44
H. S. Murphy '42 George S. Laird.... '45
E. W. Lance '43

Public Relations Committee:

Foster Orton '40 S. H. Davis '43
William McCallion '41 Horace Livengood.. '44
Norman Burritt ... '42

Legislative Committee:

William B. Fort.... '40 W. F. Phelan '43
W. J. Hallock '41 C. A. Brokaw '44
James Hanrahan ... '42

It was felt advisable to enlarge the Executive Committee by appointing to the committee the retired Presidents of the past five years, in addition to the officers of the society. This resolution was passed.

NEW MEMBERS

Dr. Irving Dolsky, Henry L. Klein, Joseph Kwint, Benjamin Yagol, Samuel Kaplon, and Richard Sims were elected to membership.

ADDRESS BY THE RETIRING PRESIDENT

With a very short, but excellent, presentation Dr. Henri Abel closed his eighteen months as President of the county society. He took this opportunity to ask the doctors to take a greater part in civic activities, to become more socially minded citizens, and to practice the art of medicine in such a way that they might again become leaders in public opinion.

Quoting from an address by Dr. Wells P. Eagleton, at one of our recent county medical society meetings, he showed how far doctors have gotten away from their preëminent position because they have merely become technicians and research workers, rather than *leaders* of public opinion. He traced this attitude from its inception in medical schools, where the student primarily works under men of research ability and is judged only on the marks he makes in technical science, rather than on his personality, common sense, and judgment.

SUMMIT MEDICAL SOCIETY

E. H. MacPherson, M.D., Secretary

The *Summit Medical Society* were the guests of the Bilhuber-Knoll Corporation of Orange, where the March meeting was held on Tuesday evening, the 28th.

Dr. Hallock, the President, presided with twenty-five members and guests present.

A film on electrocardiographic tracing of the heart was shown.

Dr. Arthur C. De Graff, Professor of Therapeutics of New York University, spoke on "Some Recent Trends in Therapy with Special Reference to Treatment of Heart Disease".

Following the meeting a collation was served.

The *Summit Medical Society* held its monthly meeting at the Nurses' Home of Overlook Hospital on Tuesday evening, April 25th. Dr. Hallock, President, presided, with twenty-nine members and twelve guests present.

As there existed one vacancy, Dr. Leonard M. Berman, of 155 Summit Avenue, was elected to membership.

The speakers of the evening were Drs. Linn J. Boyd, and David Scherf of Flower-Fifth Avenue Hospital in New York City. Their subject was "Pulmonary Embolism", which was presented in an exceptionally instructive manner.

Following the discussion a collation was served.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The spring meeting of the *Warren County Medical Society* was held at Mount's Sea Food Restaurant, near Washington, N. J., on Tuesday, April 18, 1939. The meeting was called to order at 11 a.m. by the President, Dr. C. F. Smith. Twenty-three members, and ten guests were present.

DEATH OF DR. F. W. CURTIS

Dr. H. Bossard reported the death of Dr. F. W. Curtis, of Stewartsville, on February 9, 1939. Drs. Bossard, Bloom, and Krausz were appointed a com-

mittee to draw up suitable resolutions for Dr. Curtis, and report at the next meeting.

Because of the death of Dr. F. W. Curtis, who was elected delegate to the State Society, Dr. L. Bloom was elected delegate for three years.

ELECTION

Dr. F. A. Shimer was elected a member of the Nominating Committee of the State Society, and Dr. F. Gordon was elected alternate for Dr. Shimer.

VENEREAL DISEASE

The floor was then turned over to Dr. Karl M. Scott of the Venereal Committee of the State Medical Society. He outlined the plan which the State Society wishes to adopt for the treatment of syphilis in the indigent.

The State Society wishes to establish clinics in Belvidere, Hackettstown, Washington and Blairstown for this work. The doctors in charge of the clinic in each town is to receive \$100.00 per year. This fee was to take care of the clerical expense, the nurse, alcohol, iodine and cotton. The medicine is supplied by the State, also syringes and needles. Each patient is expected to have a minimum of forty treatments annually.

Dr. Scott was then asked the status of the Phillipsburg clinic which has been operating several years.

He answered that the plan made no provision for established clinics.

Dr. J. Condron, of Easton, who has charge of the Phillipsburg clinic at Warren Hospital, stated the need for social workers to keep the patients returning to the clinic for treatments.

Dr. W. Skinner moved and Dr. G. Mills seconded that the State's plan for additional centers for the treatment of syphilis, namely—Belvidere, Blairstown, Hackettstown, and Washington—be approved. The motion was passed.

BIRTH CONTROL CLINIC

Mr. John Pursell, County Solicitor of Phillipsburg, then spoke to the society on the Birth Control Clinic in Easton, Pa., which was a follow-up talk on one given by Mrs. Bolton Love, of Easton, at our last meeting. Action which was laid on the table.

He stated that the clinic in Easton wants:

1. The Warren County Medical Society approval.
2. Members of the society on the advisory committee of the Easton clinic.
3. Inspection of the clinic by the physicians.
4. Direction or supervision of the clinic.

After much discussion it was decided that the President appoint a committee to formulate a resolution for the society on the question of the society's position in the Birth Control Clinic. Drs. Bloom, Marlatt and Mills were named on the committee and later presented the following resolution:

Resolved, that the Warren County Medical Society approves of adequate contraceptive information for the purpose of child spacing, and the avoidance of conception by women suffering from physical or mental conditions in which pregnancy is inadvisable.

The resolution was adopted.

MEDICAL CARE OF WELFARE WARDS

Mr. P. R. Thatcher, Director of Welfare for Warren County, then introduced Mr. Widenor of the State Welfare Board, who spoke on the medical care of those under the care of the Welfare Board, both outside poor and old-age pensioners, outlining the way the physician was to be paid for caring for these indigents.

ORGANIZATION RELATIONSHIPS

Dr. Norman M. Scott, Assistant to the Executive Officer of the State Society, explained the object of his visit to be:

1. To learn about the problems of the Warren County Medical Society.
2. To urge the members to interest themselves in the broad problems of the State Society.
3. To submit a list of county society members who are willing to serve on State Society committees.
4. To request the coöperation of the members of the county society in developing methods for the distribution of medical care throughout the State, so that they shall be under the control of the medical profession.

Dr. Frank Overton, Editor of the Journal of the State Society, said that he is compiling a history of the physicians of the State and the Medical Societies of the State and counties, and asked the Warren County Society to coöperate in the project of local medical history. President Smith suggested that the editor consult Dr. G. W. Cummins, of Belvidere, who has collected a considerable amount of material on medical history.

COMING MEETINGS

Dr. H. Bossard then announced the meeting of the Tri-County Medical Society at some place near Bernardsville, May 17, 1939, at noon, the speaker to be Dr. Toufick Nicola, of Montclair.

Also a meeting of the Lehigh Valley Medical Society will be held at Pocono Manor Inn, July 20, 1939, the speaker to be Harrison S. Martland, Chief Medical Examiner of Essex County.

MATERNAL WELFARE

Dr. Bingham, Chairman of the State Maternal Welfare Committee, spoke on the maternal deaths for the past year. Warren County had two.

HONORARY MEMBER

Dr. Shimer moved, and Dr. Bloom seconded, a motion that Dr. J. J. Condron, of Easton, be elected an honorary member of this society. Motion carried.

VENEREAL CLINIC

The society then went on record for support of Dr. J. J. Condron as the physician in charge of the Venereal Clinic at Warren Hospital at Phillipsburg.

Dr. Varney moved, and Dr. Shimer seconded, that the New Jersey State Medical Society be informed of the county society's action as to Dr. J. J. Condron, of Easton, Pa.

Luncheon was enjoyed with the company of the Woman's Auxiliary in the large dining room.

THE WOMAN'S AUXILIARY

STATE EXECUTIVE BOARD

By Mrs. Banks S. Baker, Recording Secretary

A regular meeting of the *Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey* was held at Bamberger's in Newark, on Monday, March 13th.

In opening the meeting, the President, Mrs. Don A. Epler, stressed the importance of serving on lay boards and spreading favorable information about the doctors. Mrs. Epler stated that the project of collecting data pertaining to Medical History should have a wide and valuable appeal to all Auxiliary members, and urged every member to contribute something in order that we may have a banner year.

Dr. Frank Overton, Editor of the Journal, talked about the Medical History of the State, and called attention to two editorials in the March, 1939, issue of the Journal, also to a list of material available for the Medical History project, which will give some idea of the work that can be done. Dr. Overton urged the Auxiliary to tell what it is doing.

Mrs. Ily R. Bier, Chairman of the Art, Hobby and Medical History Committee, submitted a report, which reads in part: "During the last four years The Medical Society of New Jersey has entrusted to this committee the collection, recording and exhibition of data and objects bearing on the Medical History of New Jersey, and this work has steadily grown until it has become a major objective of our Auxiliary. This year the formation of the Archives of the Medical History of New Jersey has been made a major objective of The Medical Society of New Jersey, and our part in this work is of direct

assistance. It is our opportunity to prove that we can do something for our men and their interests."

Mrs. Bier also urged members to enter articles and collections for the Art and Hobby Exhibit.

Mrs. A. W. Bickner, Chairman of the Committee on Legislation, advised that many bills have been introduced which are of interest to the profession, but the Medical Practice Bill known as A-210 is the most important and of vital interest to the doctors. She urged all members to contact their legislators, and to impress upon them the importance of this bill to the public as well as to the doctor.

Mrs. H. Roy Van Ness, Chairman of the Program, Health Education Committee, called attention to the articles for release to newspapers or for presentation at meetings as educational material. "Questions and Answers" available were discussed, and it was decided to have them printed and sent out to every county for use at Auxiliary meetings. Mrs. Van Ness stated that "Program-Health Education" means the arrangement of educational material available to better educate our own members to take their places on lay boards, and to answer intelligently remarks or questions which concern the medical profession.

President Epler urged all members to attend the annual convention in Atlantic City. If the doctors' wives could be made conscious of the scope of the Auxiliary and the breadth of its purpose, they would naturally become *Auxiliary-minded*. No matter how small the contribution, we need every one to make the Auxiliary a success.

Atlantic County

Reported by Mrs. Samuel Winn

The members of the Executive Board of the *Woman's Auxiliary to the Atlantic County Medical Society* were hostesses to the State President, Mrs. Don A. Epler, at a buffet supper in the home of Mrs. J. H. Mason, III, in Ventnor. After the dinner, the regular meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held in the Hotel Ambassador, Atlantic City, with thirty-two members and two guests present.

Mrs. Ruffin Stamps, Chairman of the Legislative Committee, reported that 180 letters had been sent to legislators and political leaders regarding bills on matters of legislation. Numerous replies were received from the legislators.

Mrs. Ily R. Beir, State Chairman of Arts and History, asked coöperation in her exhibit for the coming State convention, and also for an early response from the exhibitors, so as to enable her to make definite arrangements for display.

Ex-Judge Robert A. Warke gave a practical address on "Juvenile Delinquency".

Burlington County

Reported by Mrs. Freeman Metzger, Riverside

The monthly meeting of the *Woman's Auxiliary to the Burlington County Medical Society* was held on Monday, April 3rd, 1939, at Riverton Country Club, with Mrs. W. C. V. Wells, the Vice-President, presiding in the absence of Mrs. Carlton Hogan, the President. A luncheon in charge of Mrs. R. I. Downs, of Riverside, was served to twenty members.

Plans were discussed for the Health Institute to be held in Mt. Holly Regional High School on Tuesday, May 2nd, 1939, at 10:00 a. m. to 3:30 p. m. Dr. Hammell Shipps arranged the following medical program for the institute:

10:30 a. m.—Dr. T. K. Lewis will speak on "Hospital Facilities".

11:30 a.m.—Dr. Emlen Stokes will speak on "Sterilization", from both medical and legislative points of view.

1:30 p.m.—Dr. Vincent Del Duca will speak on "Child Health".

2:30 p.m.—Dr. Arthur Casselman will speak on "Pre-Marital Examinations".

Mrs. G. E. McDonnel is Chairman, and Mrs. R. I. Downs is Co-chairman of the Committee on Arrangements.

A musical entertainment at the institute will be furnished by the Mt. Holly Choral Society, and the Mt. Holly High School Chorus.

After the meeting we were delightfully entertained by readings given by Miss Mary Jane Makin, of Moorestown.

Camden County

Reported by Mrs. George B. German

The *Woman's Auxiliary to the Camden County Medical Society* held an Open Meeting on Monday, March 27th, in the Woman's Club of Camden. There were about 200 members and guests present.

Mrs. A. Haines Lippincott, recently appointed New Jersey Commander of the Field Army of the American Society for the Control of Cancer, introduced the program of the society. Mrs. Gustave Ketterer, of Philadelphia, who is Pennsylvania Commander of the Women's Field Army, was guest of honor.

The program included Dr. Helen F. Schrack on "Cancer Control", and Dr. Stella Fisher, whose subject was "Maternal Health".

The affair was arranged by Mrs. Arthur J. Caselman, Public Relations Chairman of the Auxiliary, and to it were invited representatives of all women's organizations throughout Camden County.

Mrs. Lester Wilson and Mrs. Thomas P. McConaghy poured at the tea after the meeting.

Essex County

Reported by Mrs. Frank S. Forte

The *Woman's Auxiliary to the Essex County Medical Society* held its regular monthly meeting on Monday, February 27th, at the Academy of Medicine, 91 Lincoln Park. Mrs. Gustave A. Braun, President, presided.

Satisfactory reports were received from the several chairmen. Plans for the annual bridge party were discussed and it was decided to hold it on May 2nd.

Mrs. Gustave A. Braun, the President, announced that members will serve as hostesses at the anniversary meeting of the Medical Society on March 16th.

Mrs. H. Roy Van Ness, Chairman of Program-Health Education of the Woman's Auxiliary to the New Jersey State Medical Society, spoke on the opportunities for the Auxiliary to aid other organizations plan health meetings.

Mrs. Don A. Epler, Membership Chairman, announced four new members:

Mrs. Ambrose Dowd, Newark
Mrs. Michael J. O'Grady, Nutley
Mrs. John J. Kobes, Kearny
Mrs. Joseph Fortunato, Newark

Mrs. George A. Scheller, Chairman of Widows and Orphans Committee, presented the Auxiliary with a beautiful lace tablecloth to be used for its teas.

The *Woman's Auxiliary to the Essex County Medical Society* held its regular monthly meeting on Monday, March 27th, at the Academy of Medicine, 91 Lincoln Park. Reports were received from the chairmen.

The President, Mrs. Gustave A. Braun, urged all members to write to Senator Homer C. Zink and Assemblymen in order to stimulate passage of the "Assembly Bill Number 210".

A tea was planned for the April meeting for doctors' mothers and new members. Entertaining talent will be secured from physicians' families. Each chairman will give an outline on her work for the benefit of new members.

Mrs. Frank Bien, of Irvington, was elected Captain of Cancer Control of Essex County.

Tea was served at the close of the meeting. Mrs. Gustave A. Braun, President, and Mrs. Francis Kerns poured.

The *Woman's Auxiliary to the Essex County Medical Society* entertained the mothers of doctors, and new members at a tea on Monday, April 24th, at the Academy of Medicine, 91 Lincoln Park.

A board meeting preceded the tea, at which time the various chairmen gave favorable reports.

Mrs. Don A. Epler, President of the Woman's Auxiliary to The Medical Society of New Jersey, who is also our membership chairman, and Mrs. Gustave A. Braun, President, greeted the doctors' mothers and the new members, presenting them with flowers.

The following new members were accepted this month:

Mrs. Lewis Brown, 92 Park Street, Montclair
Mrs. Abraham G. Reinfeld, 354 Clinton Avenue, Newark
Mrs. S. Bernard Kaplan, 846 South 12th Street, Newark
Mrs. George P. Koech, 625 Mt. Prospect Avenue, Newark
Mrs. Augustus Mitchell, 270 Montclair Avenue, Newark
Mrs. Louis E. Goldberg, Essex House, Newark
Mrs. Franklin G. Besson, 979 Clinton Avenue, Irvington
Mrs. Jeremiah L. Buckley, 666 Franklin Avenue, Nutley
Mrs. James De Gerome, 10 Ridgewood Avenue, Glen Ridge
Mrs. M. S. Avidan, 698 Prospect Street, Maplewood

Mrs. Charles L. Schneider, Chairman of the Nominating Committee, read the slate:

President-Elect, Mrs. J. Irving Fort
Vice-President, Mrs. Joseph Clarkin
Treasurer, Mrs. S. H. Baldwin
Recording Secretary, Mrs. Lewis Schneider
Directors: Mrs. Sidney Keller; Mrs. Frank Bien, of Irvington

Mrs. Walter B. Mount, of Montclair, showed pictures of famous paintings and lectured on same.

Mrs. Robert L. Smith, of Overbrook, sang and was accompanied by Mrs. J. Irving Fort.

Mrs. Jessie T. Glazier, Chairman of Hospitality, was in charge of the tea. Mrs. William D. Minningham and Mrs. George A. Roger poured.

Gloucester County

Reported by Mrs. Paul Pegau

Miss Martha Fenimore, of Woodbury, gave an interesting talk on the "Problems of the Visiting Nurse" at the regular monthly meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* on Thursday evening, March 16th, at the Homestead, Woodbury.

Mrs. Fred Wandall, of Clayton, President of the Auxiliary, presided at the meeting, which was well attended.

A Reciprocity Tea was held by the *Woman's Auxiliary to the Gloucester County Medical Society* on Thursday afternoon, April 20th, at 2 o'clock, at the home of Mrs. J. Harris Underwood. There were about seventy guests present, including members and representatives from other clubs in the county. A women's sextette, led by Mrs. Arthur Knapp, composed of members of the Woman's Club of Woodbury, gave several groups of songs, which were delightfully received. Mrs. Fred Wandall, President of the Auxiliary, introduced the speaker, Dr. Hilton S. Read, of Atlantic City, who gave an address on the subject "Uncle Sam, M.D." The committee in charge of the tea were Mrs. Clarence Bowersox, Mrs. Fred Wandall, Mrs. C. I. Ulmer, Mrs. Paul Pegau and Mrs. Herman Wright.

Hudson County

Reported by Nellie D. Nevin

The annual reciprocity meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on April 3rd.

Mrs. Charles B. Kelley introduced the guest speaker, Dr. Wells P. Eagleton, of Newark, who spoke on the subject "The Opportunity and Responsibility of the Doctor's Wife in the Spiritual and Economic Advancement of the Medical Profession". It is the doctor's belief that it is her duty as a woman and citizen to take part in politics and good government.

The subject of the *refugee doctor* was explained by Dr. Eagleton, who said that nearly 400 applications have been received by the Board of Medical Examiners in the State of New Jersey to become residents in one year. In closing, the doctor told his audience that they should demand representation on every Hospital Board and in the House of Delegates of the American Medical Association.

A social hour closed the meeting.

The closing meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday, May 1st, with Mrs. Charles B. Kelley presiding.

All officers and chairmen presented reports of their work during the past year, including the out-

going President, who thanked her fellow-officers and members for their loyal support and coöperation.

Mrs. Kelley was presented with the ex-President's pin, and a corsage of orchids as an evidence of the members' loving appreciation of her leadership for the past two years.

The new President, Mrs. Arthur Largay, of Bayonne, then was welcomed. In a graceful address, she assured the members that her best efforts would be put forth to continue the good work of the Auxiliary.

The officers chosen to assist Mrs. Largay are:

Mrs. E. J. Chapman, President-Elect
Mrs. A. C. Ruoff, First Vice-President
Mrs. A. Schulman, Second Vice-President
Mrs. Bernard Kelly, Recording Secretary
Mrs. Harry Perlberg, Treasurer

The delegates to attend the convention in Atlantic City, June 6th, 7th, and 8th, are:

Delegates	Alternates
Mrs. Largay	Mrs. Jaffin
Mrs. Kelley	Mrs. Chapman
Mrs. William Freile	Mrs. Ruvane
Mrs. George Culver	Mrs. Murphy
Mrs. John Nevin	Mrs. Waters
Mrs. Frank Mallaliew	

Forty members were present and Mrs. Logan Owens, of Hoboken, was welcomed as a new member.

A social hour and tea closed a most interesting meeting.

Passaic County

Mrs. Josephine E. Mott, Reporter

The annual open meeting of the *Woman's Auxiliary to the Passaic County Medical Society* was held on Thursday, March 23rd, 1939, at 3 p.m., at the Paterson Women's Club, with the President, Mrs. William Spickers, presiding, and about 150 members and guests in attendance.

Dr. Frederic James Farnell, Clinician at Vanderbilt Neurological Clinic, and instructor in Neurology at Columbia University, was the speaker of the day. His topic was "A Psychiatrist Looks on Society's Anti-Social Burdens", in which he discussed crime and the criminal, and the need for constructive substitutes for idleness in youth as a preventive against crime.

A brief business session was held.

Somerset County

Reported by Mrs. Charles F. Halsted

A special meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held at the home of Mrs. Lancelot Ely, Thursday evening, April 13th, with twenty-five members and guests present. The President, Mrs. Edgar T. Flint, presided.

Solos were rendered by Marian Tice Pach, accompanied by Mary Capewell Gustafson.

A talk on Mexico was given by Kathleen Flynn, daughter of Dr. Thomas H. Flynn.

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Meetings at Trenton at 11:00 a. m. on October 1; December 3; February 18; April 14

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Meetings at the call of the Chairmen

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WILLIAM H. VARNEY, *Vice-Chairman* Washington
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EDWARD C. KLEIN, JR. Newark
GEORGE LATHROPE Newark
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AUGUSTUS S. KNIGHT Far Hills
WILLIAM A. ANTOPOUL Newark
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OTTO R. HOLTZ Asbury Park
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FLOYD E. KEIR Englewood
ANTHONY J. DELARIO Paterson
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IRVING OKIN Passaic
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HARRISON B. WILSON Hackensack
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CLARENCE M. TRIPPE Asbury Park
HENRY A. DAVIDSON Newark
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WILLIAM M. DOODY Jersey City
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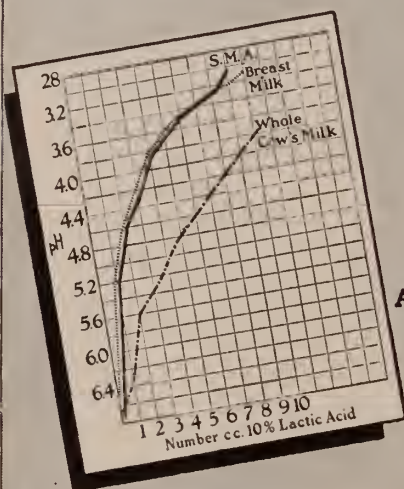
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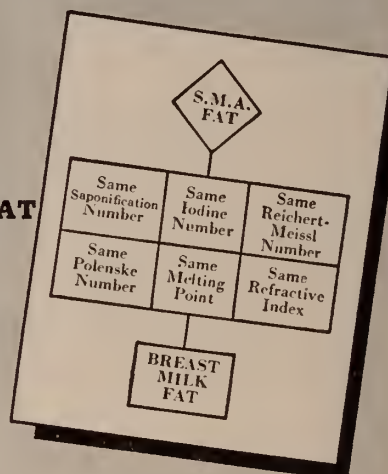
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FAT.....	3.5-3.6%	3.59
PROTEIN.....	1.3-1.4%	1.23-1.5
CARBOHYDRATE	7.3-7.5%	7.57
Ash.....	0.25-0.30%	0.215-0.226
pH.....	6.8-7.0	6.97
Δ.....	0.56-0.61	0.56
ELECTRICAL CONDUCTIVITY	0.0022-0.0024	0.0023
SPECIFIC GRAVITY.....	1.032	1.032
CALORIC VALUE: —PER 100 C. C.—	68.0	68.0
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A. Milk, whole, 24 ozs.
Boiled water, 8 ozs.
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Four feedings, eight ozs. every four hours.

Infants should be weaned from the breast at about eight months. The season of the year is immaterial with modern knowledge of nutrition and hygiene. Gradual weaning is accomplished by progressively increasing the number of bottle feedings in substitution for the breast feedings.

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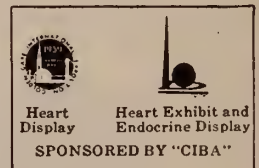


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CANNED FOODS AS PROTEIN SOURCES

● The primary function of protein in foods is that of a building material essential for tissue growth and maintenance. In 1897, Rubner postulated that all proteins are not of equal value in nutrition (1). Since that time, considerable attention has been directed towards the establishment of the types and amounts of protein required by man.

Chemical and biological investigations have demonstrated that different proteins may vary widely in both chemical composition (2) and ability to satisfy the nitrogen requirements (1, 3) of various animals. Of the twenty-odd amino acids which have been isolated from proteins (4) arginine, histidine, isoleucine, leucine, lysine, methionine, phenylalanine, threonine, tryptophan and valine have been shown to be essential in mammalian nutrition. The biological value of a protein is in reality a measure of its ability to supply those amino acids essential for tissue building and repair which the animal cannot synthesize (5) from material "ordinarily available" at a rate sufficient to meet body demands. A "complete" protein is one which will supply—or at least contains—the essential amino acids. Few proteins approach this ideal condition. Fortunately, however, a varied diet, containing proteins of both vegetable and animal origin, will usually supply all the essential amino acids which may not be supplied in adequate amounts by any one of the proteins.

As to the amounts of protein needed by men, experiments of the balance sheet or endogenous nitrogen elimination types (3, 6) have demonstrated that the protein require-

ments of the human adult may apparently be adequately met by relatively low protein intakes. These intakes are of the order of 0.5 gram per day per kilogram of body weight. However, there is evidence (3) that development of physique and general health is favored by more liberal protein intake. Since excess of protein above the requirement for tissue repair and growth is utilized as a source of fuel, the present trend is toward more liberal protein allowances.

In infancy and childhood, suggested protein allowances (3) are relatively high, being of the order of 3 to 4 grams of protein per kilogram of body weight in infancy and gradually decreasing with increasing age until adult allowances (3, 6) of 0.75 to 1.5 grams protein per kilogram of body weight are reached. Protein allowances of the order of 10 to 15 per cent of total calories as protein calories in the mixed diet throughout the entire life cycle, appear to be satisfactory. In the formulating of a mixed diet calculated to supply optimal amounts of proteins, the canned meats, marine, dairy and vegetable products may be freely used.

During recent years, popular interest has been concerned chiefly with the more recently discovered essential food factors such as the vitamins. However, the modern concept of adequate nutrition teaches that the optimum diet should be complete with respect to all known dietary essentials, protein, of course, included. In the attainment of this objective, the hundreds of commercially canned foods of animal and vegetable origin should prove both economical and valuable as protein sources.

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- (1) 1935. Nutrition Abstracts and Reviews, 4, 447
 (2) 1929. The Biochemistry of the Amino Acids, H. H. Mitchell and T. S. Hamilton, Chemical Catalog Company, New York.
 (3) 1937. Nutrition Abstracts and Reviews, 7, 257.

- (4) 1937. J. Am. Med. Assn. 109, 2070.
 (5) 1938. Annual Review Biochemistry, 7, 356.
 (6) 1938. Chemistry of Food and Nutrition, Fifth Edition, H. C. Sherman, Macmillan Co., New York.

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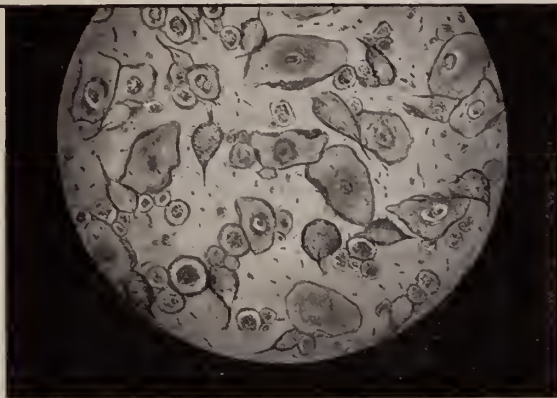


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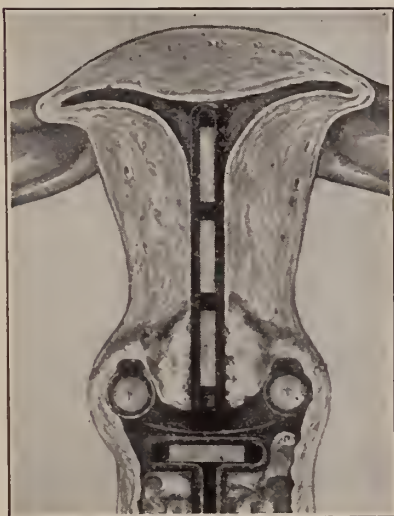
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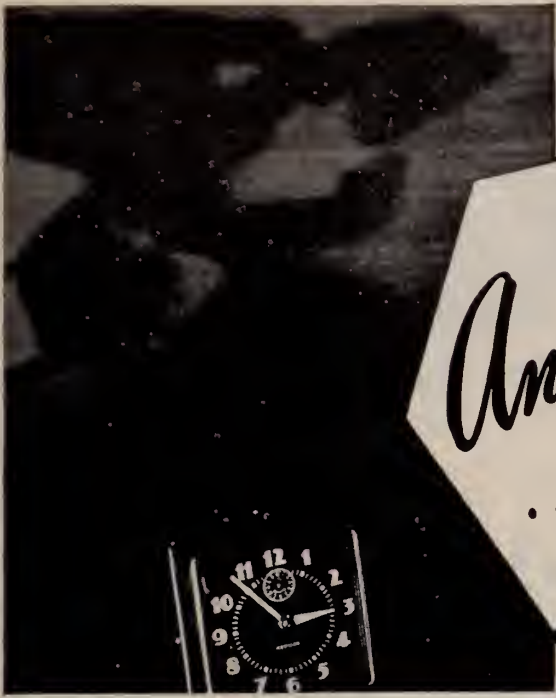
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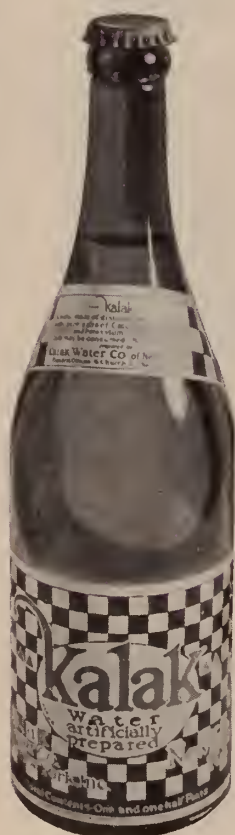
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DISCUSSING the treatment of symptoms resulting from or aggravated by hot weather and other forms of external heat, Fantus * says:

"The frequent taking of small quantities (of water) is better than large drinks at long intervals. This is especially true when the circulation is enfeebled. Carbonated drinks are preferable because they leave the stomach more rapidly, as the stomach does not absorb water. Profuse sweating robs the body of large amounts of salt . . ."

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* Fantus, B.: *Therapy of Disturbances Due to Heat*, J. A. M. A., Sept. 29, 1934, p. 990.

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Lederle

IT HAS ALREADY BECOME a commonplace experience in early and uncomplicated cases to have a pneumonia patient's temperature drop dramatically to normal in 24 to 36 hours after beginning the administration of Sulfapyridine. Such cases then usually proceed to uneventful recovery.

On the other hand, Pneumonia, "Captain of the Men of Death" is not uniformly to be disposed of so simply! The composite advice of eminent specialists embodied in the Lederle directions for use says:

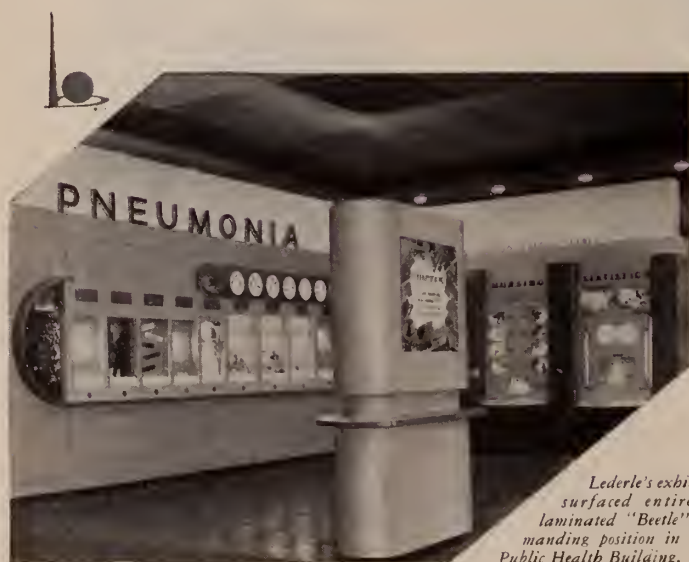
- 1—collect sputum for typing;
- 2—take specimens for blood culture and blood count;
- 3—then begin administration of Sulfapyridine;

But give serum also:

- if patient's temperature, pulse rate and respiration are not essentially normal within 24-36 hours after beginning the drug treatment;
- or if the case is of 3 days' or more duration;
- or if bacteremia is present;
- or if the patient is over 40;
- or if two or more lobes are involved;
- or if patient is pregnant or in first week of puerperium;
- or if, on account of nausea, patient cannot tolerate Sulfapyridine.

Finally, watch for contraindications for Sulfapyridine; this requires daily blood counts and urine analyses. Sulfapyridine is toxic to some and patients should be constantly supervised to detect a possible occurrence of hemolytic anemia, hematuria, or leukopenia. Nausea, the most constant side-effect, is not a contraindication.

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PUBLISHED MONTHLY

UNDER THE
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COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

Editorial and Executive Offices of the Society—143 East State Street, Trenton, N. J.; Tel. 9330

EXECUTIVE OFFICER—LEROY A. WILKES, M.D.

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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. XXXVI, No. 7

JULY, 1939

Subscriptions, \$3.00 per Year
Single Copies, 30 Cents

EDITORIAL

Schedule of Committee Meetings

The following schedule of the meetings of the Welfare Committee and its four sub-committees has been adopted:

The Welfare Committee and its four sub-committees shall meet as follows:

Sunday, Oct. 1, 1939	Sunday, Feb. 18, 1940
Sunday, Dec. 1, 1939	Sunday, Apr. 14, 1940

The four sub-committees shall meet at 10:30 a. m. in the Executive Offices in Trenton, where proper provision will be made for them. At 2:00 p. m., in the same building, the Welfare Committee meeting will be held. The reports of all of these meetings will be abstracted and published in the Journal.

ADVISORY COMMITTEES

Each advisory committee of the four sub-committees shall meet between the dates of the meetings of the Welfare Committee, at a time and place to be set by the chairman.

After the meeting, each chairman shall submit a written report, with specific recommendations, to the chairman of the appropriate sub-committee of the Welfare Committee. These reports shall be submitted on or before the dates given in the following schedule:

The program of the committee.... August 15
First report November 1

Second report January 15
Third report March 15
Summary for the Annual Meeting... April 15

Each sub-committee shall review the reports and recommendations of its advisory committees, and shall incorporate those which are approved in its report to the Welfare Committee.

The chairmen of the advisory committees are requested to send their reports on or before the scheduled date of the sub-committee meeting to the Executive Offices in Trenton. The purpose of this suggestion is to assist the sub-committee by preparing additional copies of the advisory committee's reports so that each member may have one. This can be done only if the reports are sent not later than the scheduled time.

At its first meeting, each advisory committee shall formulate its *program* for the current administrative year and shall send a copy to the Executive Offices in Trenton *on or before August 15th*, so that the programs may be printed in the September issue of the Journal.

The Board of Trustees will hold its meetings on days set apart from other meetings of The Medical Society of New Jersey, and chosen by the Chairman of the Board.

Hospital Administration

Attempts to solve the problems growing out of the relations between hospital governing boards, hospital administrators, and physicians, are of outstanding importance among the activities of The Medical Society of New Jersey during the present year.

Preliminary work in this undertaking was initiated two years ago, when a survey of New Jersey hospitals was instituted by the Hospital Relationships Committee of this Society under the direction of Dr. T. K. Lewis. The spirit of this initial survey was entirely impartial and constructive in nature. The report was approved by the House of Delegates of this Society in June, 1939, and instructions were given to distribute copies of the report to the hospital administrators and hospital governing boards of the hospitals of New Jersey.

In order to advance this work and encourage the existing friendliness and coöperative spirit already existing between the two societies, a joint session of the New Jersey Hospital

Association and The Medical Society of New Jersey was held at Atlantic City, N. J., on June 8th, at which the Hospital Relationships Committee of The Medical Society of New Jersey presented its report. The meeting approved the report, and authorized the appointment of a joint committee of members from each organization to continue the study of their common problems, and to develop their solution.

At this joint session an outstanding paper by Dr. G. Harvey Agnew, Toronto, Canada, on "The Doctor and His Workshop" was presented, which is printed on page 424 of this Journal.

Dr. William J. Carrington, President of The Medical Society of New Jersey, presented at this session an excellent paper on the subject of "Hospital Relationships", bringing out some of the most pertinent results of the investigation of our Hospital Relationships Committee. This paper is printed on page 410 of this Journal.

Influencing Medical Legislation

The five thousand physicians of the State of New Jersey can wield an overwhelming influence in medical legislation if they exert it along certain lines that are entirely ethical.

The Medical Society of New Jersey has an enrolled membership of 3473, of whom 813, or 25 per cent, registered their attendance at the annual meeting, and gave their unanimous support to larger measures of the utmost importance to public health, such as hospital administration, insurance for medical care, and the control of tuberculosis and venereal diseases.

The success of medical legislation depends on the influence which each individual physician has upon his local representative in the Legislature. There are two ways by which he can exert that influence effectively:

1. He can explain his views to his representative in a personal visit.

2. He can get half a dozen of his prominent friends to visit the representative, or write him a personal letter asking him to vote in support of the scientific practice of medicine.

If each of the 813 physicians who attended the annual meeting of The Medical Society of New Jersey would do this, the total figures would be:

Direct approached to Legislators...	813
Approaches to Legislators by prominent citizens (813 times 6)	4278
Total contacts	5091

Since the number of members of the two branches of the Legislature is 81, each member would be approached by an average number of 60 of his influential constituents.

Legislators will respond to this number of personal appeals.

Hospital Relationships

Among the activities of The Medical Society of New Jersey during the present year, attempts to solve the problems growing out of the relations between hospital administrators and physicians are of outstanding importance.

The report of the Hospital Relationships Committee, which has studied these problems, will be found on page 414 of this issue. It deals with the services rendered, together with their costs and the income received from them. It also deals with the patient, the hospital administrator, and the doctor, together with their inter-relations.

The study is also impartial and reveals defects and conflicting points of view which warrant still further investigation and corrective action.

The committee has expressed its desire that the subjects discussed in this report be given maximum publicity among physicians, hospital administrators, and governing bodies; and it is confident that, when these groups are conversant with the contents of the report, a satisfactory solution of the problems, based upon mutual understanding, will be reached.

Legislation

On the afternoon of Monday, June 26, the last step in the adoption of the Medical Practice Act, Assembly 210, was taken by the Assembly on June 27, by concurring in minor amendments which had been made by the Senate. The Bill is now before the Governor, and his approval will establish its provisions as the laws of the State of New Jersey.

Four major provisions of the Bill are as follows:

1. After five years, those wishing to practice chiropractic will have to conform to the educational standards of other legalized practitioners of medicine and surgery.
2. Increased penalties are provided for violations of the Medical Practice Act.

3. Citizenship will be required of all practitioners of medicine and surgery.

4. Enlarged grounds for the revocation of licenses to practice medicine,—for example, insanity is added.

Write to Governor Moore asking him to sign the Bill,—and even more important, get influential citizens to do the same.

On June 26, the Senate voted to pass a Chiropractic Bill which would nullify the provisions of the Medical Practice Act so far as they apply to chiropractors. Five Senators who voted for the Medical Practice Act also voted for the Chiropractic Bill, although these Bills are contradictory.

Diathermy Treatment and Television

Broadcasting companies, particularly those interested in television, have complained to the Federal Communications Commission that some of the x-ray and diathermy machines used by physicians in diagnosis and treatment are interfering with radio transmission and reception. A greater number of complaints are concerned with the older type of diathermy machines in which a spark gap is used.

An explanatory article on the subject was printed in the Archives of Physical Therapy of May, 1939, page 261.

The subject is under consideration by the Committee on Auxiliary Medical Services. It would seem that its first action would be to ascertain the number and type of the spark-gap machines used in physical therapy and x-rays, and the cost of their replacement with modern equipment.

ORIGINAL ARTICLES

THE HOSPITAL AND THE DOCTOR

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

President, The Medical Society of New Jersey

An address before the joint meeting of The Medical Society of New Jersey and the New Jersey Hospital Association, at Atlantic City, June 8, 1939.

The term *doctor* means an individual who has had adequate medical training, and who is licensed by the State to diagnose and treat the sick and injured.

The term *hospital* refers to an institution in which sick and injured are given surgical and medical treatment. It is not merely a workshop for the doctor, maintained by tax funds and donations for the doctor. The patient, not the doctor, is the first and final consideration. When we forget these definitions our troubles begin.

On the other hand, the hospital is not the health center of the community where rich and poor come for curative and preventive treatment. Some administrators, and some government officials in high places would have it so. The office of the family doctor is the health center of the community. When we forget this our troubles multiply.

The relationships between hospital and doctor have many confusing ramifications, all of which are of mutual and even vital interest to administrators and physicians. There are 5433 doctors in active practice in New Jersey. Three thousand and twenty of them are directly affiliated with hospitals within the State, of which five are Federal; sixteen, State; twenty-four, county; ten, municipal; eighteen, church; two, fraternal; seventy-three, non-profit; and twenty-two, proprietary. While more than two thousand doctors of the State are not staff members, they frequently refer cases to these hospitals and utilize their laboratory and therapeutic facilities.

A generation ago the doctor and the hospital had comparatively few complexities, and fewer misunderstandings. While the doctor was es-

sential to the hospital, the hospital was not essential to the doctor. Today things are different. They are interdependent. Diagnosis is much more complex. Today 85 per cent of sick people suffer with illnesses which can be diagnosed with no more complicated instruments than can be carried about in the doctor's handbag, but 15 per cent require expensive apparatus and special skill. These are often available only in the hospital. Treatment also is more complex and may require costly instruments or constant observation which are often to be had only in the hospital.

Home surroundings of patients are different today. We are becoming a nation of cliff-dwellers in apartment houses. Gone are the spacious spare bedrooms of yesterday, and the sun-kissed verandas. The doctor is coming more and more to depend upon the hospital, and he is not leaning on a broken reed. During the depression, thousands of commercial firms went into bankruptcy. Investment houses and banks closed their doors, but not a single hospital has defaulted its service to humanity. For this the public and the medical profession are eternally grateful.

HOSPITAL PRIVILEGES

One of the modern complexities is the question of *hospital privileges*. The small community hospital may have every doctor in good standing on its staff, thus granting equal privileges to all. But the large community hospital faces a very real problem. Closed hospitals permit closer coördination of services, better staff development, and more effective treatment. On the other hand, it is only fair to keep private wards, at least, open to all reput-

able doctors in the community who conform to hospital practices. The income of the institution depends somewhat, at least, upon the good will of all of the physicians. The goal is to provide every courtesy compatible with good medical care. Nevertheless, the reputation of the hospital is at stake. Unscrupulous, careless and over-ambitious doctors must be limited in their privileges. According to the tenets of the British Medical Association, hospitals of one hundred beds or less should be open, and larger hospitals should be closed.

MEDICAL STAFF

The *Medical Staff* is an important factor in any hospital. Upon it depends the success or failure of the institution. No hospital can be more serviceable or more famous than its staff. Choosing personnel on merit alone is as difficult as it is desirable. Too often politics, social and denominational connections, and even the financial needs of the institution determine staff selection. Large contributors and powerful corporations sometimes demand the appointment of inferior men. Chiefs should hold fellowships in the various colleges. Surgical chiefs should be Fellows of the American College of Surgeons, and medical chiefs should be Fellows of the American College of Physicians. Better hospitals will soon require diplomas from the various American Specialty Boards. Appointments should be made by the Trustees only upon the recommendation of the staff, and the staff should recommend on a two-thirds vote after careful consideration by a committee. Fee splitting must be rigidly prohibited and staff membership should be limited to members of the County Medical Society or the County Dental Society. Hospitals have found that doctors who subject themselves to discipline by their fellows are more alert, more informed, and more ethical than those who will not or cannot belong to the County Medical Society. If this be monopolistic, then the Bureau of Weights and Measures is monopolistic. Intolerable situations have arisen where Trustees have disregarded this fundamental rule.

The size of the staff depends upon several conditions, chief of which is the number of

patients in the several services. As a rule, superior medical men are too busy with private work to devote more than two or three hours a day to hospital charity work. It is a mistake to ask doctors for more, though they are as charitable as St. Luke and as ambitious as Caesar. Staff appointments should be made annually. Failure to reappoint is easier than dismissal. Advancement should be made not solely upon seniority but upon ability, research work and quality of service.

LENGTH OF SERVICE

Shall medical men serve two, three, or six months and then retire for the remainder of the year or shall they serve continuously? Both plans have advantages and disadvantages. Frequent changes require changes in apparatus, instruments, and technic. Rotation is undoubtedly less efficient and more expensive. On the other hand, continuity limits the number of men on the staff, and hence diminishes the inflow of private patients. Moreover, continuous service tires men out. Fatigue, indifference, and carelessness are reflected in the work of assistants and internes.

INTERDEPARTMENTAL RELATIONS

Relations between the various departments of the hospital are important. The field of medicine is so vast that many specialties have arisen. However much we may favor specialization, the fact remains that there are actually but four or five fundamental departments: surgery, medicine, pediatrics, obstetrics, and gynecology. When genito-urinary surgeons, brain surgeons, orthopedic surgeons, nose and throat surgeons, oral surgeons, ophthalmological surgeons, and dental surgeons are all given separate services, there is endless confusion. To secure coöperation, it is wise to have four or five departments and to ask the surgical, the medical, the pediatric, and the obstetrics and gynecological staffs to formulate their own rules and technics, which should be observed without costly and confusing variations.

CONSULTING STAFF

The Consulting Staff is important. Medical men grow seer and yellow. If kept on active service, they impede progress. Let us confer

high emeritus honors upon them, release them from active attendance, and retain them for consultation. Younger men will still lean on their judgment and experience.

Should an automatic retirement age be fixed? A rule works automatically without personal reference and softens the blow. Whether the age limit of active service be sixty, sixty-five, or seventy years, depends upon local conditions, which include the availability of younger men.

JUNIOR STAFF

The Junior Staff includes associates, assistants, and younger doctors who take care of out-patient departments. Members of the Senior Staff should not attempt to do all the work. They are too busy and have too little time. Many have out-worn the ambitions of youth. Younger men are anxious to contribute to the literature of the profession, to institute new practices, and to explore new fields. These young career-carvers need only opportunity and direction from older men to obtain results which will redound not only to their own success but to that of the hospital as well. There should be enough of these young men to work up and exhaust the material in every hospital.

THE DOCTOR AND THE SUPERINTENDENT

In the last analysis, lay directors, who appoint the staff, are responsible for the scientific work, the ethics, and the morale of the hospital. The superintendent is their duly delegated enforcement officer. While neither the directors nor the superintendent can escape legal responsibility, both should encourage the staff to discipline its own members. Friction can be avoided when staff members request instruments, supplies, and equipment for which funds are not available. Instead of a curt "No", let us sit down together at a conference around a table and study the budget. Frequent conferences clear away the fogs and mists of misunderstanding.

MEDICAL STAFF AND BOARD OF DIRECTORS

Relationships between the Staff and the Board of Directors are exceedingly important. What part should the Staff take in administrative activities? Administrative differ from clinical problems, and are little appreciated by

the Staff. A sharp line of demarcation separates the two. No self-respecting Staff member would tolerate interference by the administrator with his free judgment as to treatment. By the same token, he should refrain from attempting to dictate policies of administration. While the Staff should be encouraged to take an interest in administrative affairs and the administrator should be encouraged to take an interest in the clinical work, the attitude of both should be one of sympathetic coöperation. The promotion of mutual understanding is one of the greatest problems every hospital faces. Frequent regular conferences between the Staff or its executive committee and the Board are highly desirable. We doctors sometimes forget that the Board members, who are legally responsible for the management and financial support of the institution, serve without recompense. The desire to serve mankind is the sole motive for their philanthropic endeavor.

INTERNES

Few Staff members fully realize their responsibility to internes. So-called responsibilities are actually opportunities. No man can teach without learning. No man can discuss a case with his interne without clarifying his own thoughts. No hospital can train internes or nurses without improving the character of the work done in the institution. The kindly chief will be revered like a father. The chief should be the father of the mind and soul, whereas the parent is but the father of the temporal body. It is now generally agreed that hospitals that cannot offer organized training for at least three internes should not assume the educational responsibilities of the fifth year of medicine. Such hospitals will have to employ paid residents. At present there are 734 hospitals in the United States approved for the training of internes. These provide a total of 7,373 internships, but there are approximately 900 positions which cannot be filled from our own medical schools.

FOREIGN CITIZENSHIP

The influx of graduates from foreign medical schools is a problem of major importance both in hospital training and licensure. During

1937-38 there were 1,336 citizens of the United States enrolled in medical schools abroad, and 318 of them graduated. But this is only a part of the problem. In 1937, there were 919 foreign graduates permitted to take examination for licenses in the various states, mostly on the Eastern seaboard, and 147 of these were licensed to practice. In 1937, twelve hospitals in New Jersey employed eighteen foreign graduates. In 1938 fourteen New Jersey hospitals employed thirty-three foreigners as internes. The American Medical Association has adopted the following resolution in an effort to solve the perplexing problems associated with graduates of foreign medical schools:

"Resolved that when suitable graduates of Class A schools of the United States and Canada are not available, hospitals approved for interne training may accept graduates of European universities who have passed Parts I and II of the examination of the National Board of Medical Examiners."

If the Medical Practice Act, Assembly Bill 210, sponsored by The Medical Society of New Jersey, becomes a law, only citizens of the United States will be permitted to take examinations by the State Board of Medical Examiners. There has been some opposition to this by those who believe in unrestricted immigration. The proposed Medical Act was not directed against refugee physicians, but has been a part of each Medical Practice Act sponsored by The Medical Society of New Jersey for many years. American doctors who fought in the World War under the flags of the Allies and who wanted to practice in the lands for which they risked their lives were denied the privilege in every country on earth except Iraq and Albania.

If refugees want to enjoy the blessed privileges of America, they should be required to become citizens. At present they are required to signify every six years their intention of becoming citizens. If A-210 become a law, it will be five years before these refugees can practice medicine here. That means that many will be seeking employment in our hospitals as technicians of one sort or another.

COMMITTEE ON HOSPITAL RELATIONSHIPS

Three years ago The Medical Society of New Jersey began a survey of the hospitals of the State. Its Committee on Hospital Relationships, under the leadership of Dr. T. K. Lewis, of Camden, published progress reports in the *Journal* from time to time. This year, under Dr. Spencer Snedecor, a former President of our Society, Dr. Henry Becker, of Camden, completed the work. The final report has been arranged by Dr. Norman Scott, Assistant Executive Secretary of The Medical Society of New Jersey. This survey is available and will be distributed to hospital executives and to the doctors of New Jersey. It contains evidence of gross defects in relationships between hospitals and doctors and makes a number of very definite recommendations for their correction. Let me give you a preview of this report and these recommendations.

SOURCES OF INCOME

The survey showed that only 3.9 per cent of the income of New Jersey hospitals is derived from endowment. Seventy-five per cent of the income is derived from self-sustaining private patients, the remainder from donations and tax money. It is quite evident that private patients, therefore, pay for more service than they receive. The care of the indigent in hospitals should not be saddled upon that portion of the population that happens to be sick at the moment.

The survey shows that the cost of essential hospital care of ward cases ranges between a dollar and fifty cents to four dollars per day; that the same care given semi-private patients ranges between three and six dollars per day; and that private room patients pay from three dollars and fifty cents to fifteen dollars and more. Twelve hospitals showed an income of \$533,719 from patients in wards for which attending physicians and surgeons received no fees. Bearing in mind that the greatest source of income for both hospitals and the doctors is from self-respecting, independent individuals of moderate circumstances, the prices charged for private rooms precludes the possibility of their use by many of these

persons, with resulting economic loss to hospitals and to doctors.

Three observations, therefore, are made: First, hospital income from private-room and private-ward patients presents a problem that requires careful thought of all concerned; second, there should be a readjustment of private-room charges; and third, there should be an increase in accommodations for private care of persons in moderate circumstances, consisting of small unpretentious rooms at the lowest range that will meet operating expenses.

The survey of The Medical Society of New Jersey showed that most out-patient departments were poorly organized, and have no fixed policies or professional contacts between the out-patient staff, the house staff, and the governing body. Three recommendations, therefore are made: First, that the method of appointment of the out-patient staff be improved; second, that the out-patient staff be brought into closer coöperation with the house staff and the governing body; third, that no part of clinic fees be paid to physicians. Doctors are willing and anxious to contribute their time and service to the really deserving, but they should be protected by the hospital from those who, although able to pay, abuse the clinics. Last year the doctors of New Jersey gave

gratuitous services to the poor conservatively estimated at \$24,000,000.

Two broad resolutions grow out of these considerations:

First, that general policies and plans regarding all phases of hospital management, administration and their relation with the professional staff, and with patients be established in New Jersey by a committee composed of representatives of managing boards, professional staffs, the administrators, the officers of the New Jersey Hospital Association, and The Medical Society of New Jersey.

Second, that these policies when tentatively determined be widely publicized among staff members, board members, administrators, and county medical societies for the purpose of determining common policies acceptable to all.

In conclusion, let me salute the officers of the New Jersey Hospital Association for arranging this meeting. This country needs just such far-sighted statesmanship in solving the problems of hospital administration. Only in conferences such as this can seemingly conflicting ideas be welded into a common co-operative effort. For the doctors of New Jersey, let me pledge you to work hand in hand with you for the welfare of mankind.

HOSPITAL RELATIONSHIPS

A SUPPLEMENTARY REPORT OF THE COMMITTEE ON HOSPITAL RELATIONSHIPS GIVEN BEFORE THE HOUSE OF DELEGATES, JUNE 6, 1939

By SPENCER T. SNEDECOR, M.D., Chairman

For original report, see May Journal, page 285.

The following report is based on studies by the Hospital Relations Committee which was designated during 1937 to analyze the organization and operation of general hospitals in this State for the purposes of:

1. Improving the relationship between the governing, administrative and professional staffs;
2. Improving the efficiency of the service rendered to patients by all concerned.

At preliminary meetings of the Committee it was decided to submit to each hospital a questionnaire, which should cover all phases of hospital activities.

Forty-six general hospitals participated.

The answers to the questionnaires were obtained by members who visited the respective hospitals for that purpose.

Some questionnaires were incompletely answered. On some the answers were at variance with self-evident and admitted facts which became more confusing and contradictory when supplementary answers were submitted. Answers to the questions relative to income and expenditures were confusing to the Committee and were incorrectly interpreted by them.

Despite this, enough information is available

to give a good picture of hospital organization and administration, and their relationship with the professional staff.

GENERAL HOSPITALS OF NEW JERSEY

As physicians in private practice, we are more interested in the operation of general and special hospitals as distinct from those providing domiciliary care or the special care of men-

tal diseases and tuberculosis. There are in this State eighty-three such hospitals, seventy-seven of which are voluntary and six governmental. Proprietary hospitals are not included in this group.

BED CAPACITY

The total bed capacity of these eighty-three general and special hospitals is enumerated in the following table submitted by Dr. Frankel:

	Number of Hospitals	Total	Beds	Bassinets
Total	83	14,934	12,859	2,075
Voluntary (non-profit)				
General	72	11,931	10,163	1,768
Orthopaedic	3	196	196	....
Children's	1	60	60	....
Eye, Ear, Nose and Throat	1	69	69	....
Governmental (city and county)				
General	5	2,178	2,121	57
Maternity	1	500	250	250

BED CAPACITY

	Total	Private and Semi-private	Ward
Patients admitted	292,000	112,000	180,000
Patients treated	306,000	116,000	190,000
Patient days	3,725,000	1,185,000	2,540,000

PER CENT

Patients admitted	100.0	38.7	61.3
Patients treated	100.0	38.1	61.9
Patient days	100.0	31.8	68.2

The average hospital stay of patients was 11.7 days for all patients in 1937, 10.2 for private and semi-privates, and 13.0 days for ward patients. The most significant figures in the above table is 31.8 per cent representing the patient days of private patients.

ADMISSIONS

BED OCCUPANCY

The rates of bed occupancy of the private and semi-private and of ward facilities of the hospitals in 1937 were as follows:

attended a meeting of the Committee and has since contributed much information which will be incorporated in this report to clarify the question of income, costs and deficits.

Type of Patient	Number of Beds	Patient Days	Per Cent of Bed Occupancy
Total	14,934	3,725,000	68.3
Private and semi-private	5,331	1,185,000	60.9
Ward	9,603	2,540,000	72.5

OUT-PATIENT SERVICES

The extent of the out-patient services rendered during 1937 in the eighty-three hospitals may be measured by the following figures:

Number of out-patient admissions . . .	500,000
Number of out-patient visits	1,500,000

The above tables are based entirely upon data received from Dr. Emil Frankel, statistician for the State Department of Institutions and Agencies. This data is included for the

purpose of supplementing the Committee's report to give a more complete picture of the activities of general hospitals than can be obtained from analysis of the reports of the forty-five hospitals the Committee has surveyed.

INCOME AND EXPENDITURES OF HOSPITALS

The general efficiency of the services rendered by a hospital is largely dependent upon its financial support. For this reason physicians are anxiously concerned and interested in the source and adequacy of the financial support of the hospital serving their patients.

The Committee carried on an extensive investigation concerning the source of income. Interpretation of questions by hospital administrators relative to income showed such wide variation that the results were in some cases confusing and incorrect. Dr. Emil Frankel of the Department of Institutions and Agencies

Cost per Capita per Day	Number of Hospitals Reporting	
	Non-governmental	City and County
Under \$3.00 .....	..	1
\$3.00 to \$3.99	3	1
\$4.00 to \$4.99	27	..
\$5.00 to \$5.99	15	2
\$6.00 to \$6.99	7	..
\$7.00 to \$7.99	2	..
\$8.00 to \$8.99	1	..

COST PER DAY PER INHABITANT

This \$18,350,000 amounts to \$4.28 per inhabitant, of which \$2.33 is paid by the patient, leaving a deficit of \$1.96 per inhabitant.

4,343,000 Population (1930 Census)
\$4.28 Cost per inhabitant

\$18,588,040.00 Total Hospital Expenditure

COST PER DAY PER HOSPITAL PATIENT

Fifty-nine of these eighty-three hospitals reported daily cost per capita for 1937 as follows:

The average cost per capita for 1937 was \$4.95. The average cost per capita for ward patients was \$4.50. Forty-four of these reporting hospitals operate within the price range of \$4.00-\$6.00.

3,725,000 Patient days
\$4.95 Per capita cost per day

\$18,438,750.00 Expenditures of Hospital

The allowance of \$1.75 per ward day allowed to municipalities by Financial Assistance Commission is insufficient in itself to pay ward costs. Some municipalities do not supplement this with sufficient money to pay actual costs.

HOSPITAL INCOME AND EXPENDITURES (Dr. Emil Frankel)

Total expenditures for 83 hospitals \$18,350,000.00
Income:

1. Receipts from patients \$10,265,000.00
2. Receipts from
 - a. Taxes
 - b. Contributions
 - c. Endowment income 8,085,000.00

\$18,350,000.00

3. Finance Assistance Commission assists in payment of ward care for indigents at the rate of \$1.75 per day as a reimbursement to participating municipalities.

INCOME OF VOLUNTARY HOSPITALS

There are seventy-seven voluntary hospitals. The sources of income of these hospitals are as follows (Dr. Frankel, 1937):

Source of Income	Amount	Percent
Patients	\$ 9,774,000	66%+
Incidental Services	435,000	3%+
Voluntary Contributions ..	1,825,000	12%+
Tax Funds	1,741,000	12%+
Endowment Income	725,000	5%+
Total	\$14,500,000	

Receipts from patients includes money received in payment for hospital care from all sources, individual patients, insurance companies, private philanthropy to individuals and the municipal and county payment for indigent patients.

In the Committee survey thirty hospitals reported on source of income showing that of

the total received from patients 61 per cent came from private and semi-private patients in these hospitals.

HOSPITAL DEFICITS

Deficits may be considered as the difference between income from patients and total expenditures. It is made up from—

1. Taxes
2. Contributions
3. Endowment income

Deficits for the year 1937 amounted to about 32 per cent of total expenditures.

In the voluntary hospitals noted above the deficit totalled \$4,726,000, which was made up as follows:

Contributions	12%+	of total expenditures
Taxes	12%+	of total expenditures
Endowment Income ..	5%	of total expenditures

CONCLUSIONS

That—Of the total expenditures, patients contributed 66 per cent.

Of the total amount received from patients the private patients pay two-thirds, although they receive only one-third of the patient days.

Ward patients pay about one-third of the total, although they account for two-thirds of total patient days at a cost per day of only 10 per cent less than the average cost for all.

Municipalities or other government agencies do not contribute sufficient money for the care of indigent patients.

HOSPITAL RATES

The actual average cost for all patients in 1937 was \$4.95 and for ward patients \$4.50, as determined by the Department of Institutions and Agencies.

Bearing this average cost figure in mind, we submit the rates charged for ward care by thirty-five hospitals reporting to the Committee.

WARD RATES

Number of hospitals reporting	35
Hospitals with fixed rates	33
\$1.50 per day	1
1.75 per day	2
2.00 per day	6
2.50 per day	3
2.75 per day	1
3.00 per day	13
3.50 per day	2
3.75 per day	1
4.00 per day	2
.....	33
Free	1
According to ability to pay	1
.....	35

CONCLUSIONS

None of the hospitals in this survey charged for ward rates a sufficient amount to cover average cost of ward care.

All hospitals reporting care for ward cases at a monetary loss.

SEMI-PRIVATE ROOM RATES

Number of hospitals reporting .. 44

Fixed Rates	No. of Hospitals
\$3.00 per day	3
3.50 per day	4
3.75 per day	2
4.00 per day	13
4.50 per day	6
5.00 per day	10
5.50 per day	1
6.00 per day	4
.....	43

These are the low rates for 43 hospitals

Fixed Rates	No. of Hospitals
\$3.00 per day	1
3.50 per day	1
3.75 per day	1
4.00 per day	7
4.50 per day	7
5.00 per day	14
5.50 per day	6
6.00 per day	5
11.00 per day	1
.....	43

One hospital charges \$30.00 a week

Total Reporting

These are the high rates for the same 43 hospitals

The average rate for semi-private accommodations in this group is \$4.65. This \$4.65 is sufficient to pay average ward cost per day, but in several of these hospitals the rate is below this average. Eighteen of these hospitals do not charge enough to cover the average cost of all patients, and the majority can make little or no profit from semi-private patients.

PRIVATE ROOM RATES

Number of hospitals reporting

Low Rates	No. of Hospitals
\$3.50 per day	1
4.00 per day	1
4.50 per day	1
5.00 per day	11
5.50 per day	1
6.00 per day	15
6.50 per day	3
7.00 per day	7
7.50 per day	1
8.00 per day	1
10.00 per day	1
.....	43

High Rates	No. of Hospitals
\$5.50 per day	1
6.00 per day	7
6.50 per day	1
7.00 per day	7
8.00 per day	2
8.50 per day	1
9.00 per day	3
10.00 per day	8
11.00 per day	1
12.00 per day	3
12.50 per day	1
14.00 per day	2
15.00 per day	2
No limit	4
.....	43

CONCLUSIONS

There is a wide dispersion in the rates charged for private room cases. These rates pay for the same essential service given the ward and semi-private room cases, plus a larger amount of floor space occupancy, and plus extra non-essential equipment and conveniences.

The majority of hospitals make a profit on private room patients. The Committee realizes there is a certain demand for high-priced rooms, and that private room care must of necessity be expensive. In spite of this, the Committee feels that in many cases the private room patient makes an unwarranted contribution to the cost of care of ward patients.

Hospital deficits resulted from the care of ward cases.

It is believed that the cost of ward patients, who are public charges, should be distributed among the entire civilian population by tax funds, and that sick private patients should not be forced to pay more than their share, particularly during periods of illness when many find it difficult to solve their own economic problems.

The Committee believes that the basis upon which private room costs are determined is faulty.

Bearing in mind that the greatest private source of income for both the hospital and physician is from the self-respecting, independent individual of moderate circumstances, the prices charged for private rooms preclude the possibility of their use by many of these persons. This results in a deleterious economic effect upon both hospital and physician.

RECOMMENDATIONS

1. The Committee feels that the hospital income derived from private rooms and from patients in wards presents a problem that requires the careful thought of all hospital executives.

2. The Committee recommends that there be a readjustment of the basis upon which charges for private rooms are made.

3. The Committee recommends an increase in the accommodations for the private care of persons in moderate circumstances. These accommodations to consist of small, unpretentious rooms coming within the lowest price range which will maintain their operating expenses, or in the form of private pay wards with attached rooms for special care of post-operative cases and acutely ill or disturbing medical cases.

4. That a determined effort be made to force municipalities or other agencies referring indigents to hospitals to pay hospital fees commensurate with actual cost of ward care.

OUT-PATIENT DEPARTMENTS

There are forty-six hospitals reporting, of which five have no out-patient department or out-patient staff.

SUPERVISION OF OUT-PATIENT DEPARTMENTS

There is a great variation in methods of administering out-patient departments. Some hospitals have out-patient Medical Directors, others are administered under the direction of the Hospital Chief of Staff, Hospital Superintendent, or a committee from the Hospital Staff.

	Hospitals
<i>Professional Staff</i>	
No Out-Patient Staff	5
Organized Staffs	8
No organized Staffs	29
Hospital and O. P. Staffs combined	21
Distinct Staff for O. P. Department	7
<i>House Privileges to Out-Patient Department Staffs</i>	
Full privileges	10
Private patient privileges	5
Obstetrical and Medical	2
Junior Members, limited privileges	1
Junior Members, full privileges under supervision	2
<i>"Does the Out-Patient Staff have representation on the House Staff?"</i>	
"Yes"	16
"No"	4
Out-Patient Staffs are also on House Staff	5
Yes, by Chief of Clinic	2
<i>Contact with Governing Body (O. P. Staff)</i>	
Through House Staff	8
Through Medical Board	1
No contact	5
<i>Channels of Expression to Governing Board</i>	
Through House Staff	3
Personal letter	1
Through Medical Board	1
Through Medical Director	1
Through Executive Staff Committee	1
Through Dispensary Chief	4
<i>Internes in Out-Patient Departments</i>	
Required	22
Not required	2
None	3
Very little	1
Encouraged	1
Occasional	1
No internes	11
<i>Out-Patient Fees</i>	
Fixed fees	28
No fees	10
Twenty-five cents	14
Fifty cents	17
Variable	1
Up to one dollar	1
From \$1.00 to \$3.00	4
<i>Staff Meetings—O. P. Departments</i>	
Irregular	1
Regular, in those with organized staffs	8
Meetings are usually clinical conferences	

(It is assumed after studying the reports that the majority of hospitals conduct no Out-Patient meetings.)

CONCLUSION

Most out-patient departments are insufficiently organized and have no fixed policies of administrative and professional contact between the out-patient staff, house staff and governing body.

RECOMMENDATIONS

The Committee recommends that effort be made—

1. To improve methods of appointment, organization and promotion of the out-patient staff.
2. To bring the out-patient professional staffs into closer coöperative effort with the house staff, administrative staff, and the governing bodies of the hospitals.
3. To adjust out-patient fees to assist in covering the operating expense of the clinic, and not with the idea of receiving money for the physician's service or in any way competing with the physician in private practice.

SOCIO-ECONOMIC INVESTIGATIONS

1. Efforts to control the admission of patients to dispensaries and to prevent abuse of clinics by persons able to pay for private care was reported as follows:

	Hospitals
Effort made	35
No effort	2
Emergency service only	1
Private patients only	1
No dispensary service	2

2. Who exerts this control?

Social Service Workers	23
Staff members	2
Admitting Officer or Registrar	4
Superintendent	1
Special agents	1
Admitting Physician	1
Superintendent of Nurses	1
Nurse	1

3. Basis for admission to Free Dispensary

Ability or inability to pay	5
Indigency for criterion	4
Personal investigation	4
Earnings of head of family (one hospital had a definite income scale as a working basis)	3
Letter from physician	6

4. Professional supervision of Admissions

Controlled by physicians	1
Advise of physicians desired	1
None existent	13
Staff committee to coördinate social service activities	9
No coördination or coöperation between Social Service and staff	21

Patients referred to private physician if patient agrees to pay physician	39
Refused to refer patients to doctors for private care	0

The question of referring a case to a private physician arises on rare occasions.

CONCLUSIONS

The part of the questionnaire relating to this activity is faulty and incomplete. Perhaps for this reason the answers were unsatisfactory.

RECOMMENDATIONS

Because of the well-known lack of organization and policies regarding social and economic investigation, and its importance in protecting both hospital and physician, the Committee recommends that definite action be taken to improve the organization and functions of socio-economic investigations.

There must be more uniform standardization of policy and procedure to determine by credit investigation the inability of a patient to pay a private physician.

HOSPITAL ORGANIZATION—ADMINISTRATION

Management—Total reporting, 46 hospitals

	Hospitals
1. Governing Boards	
Self perpetuating	22
Elected by hospital corporation	19
County or municipal control	3
Church management	2

2. Relation of Board to Hospital Management

To what extent does Board enter into actual management of hospital?

Through Executive Committee and Superintendent	32
Through Executive Committee only	2
Through Superintendent	2
No channel of communication	10

3. Responsible for Management of Hospital

Financial Policies	
Governing Board	37
Board and Staff	9
Business Management	
Superintendent	19
Medical Director	3
Board	4

CONCLUSIONS (Paragraphs 1, 2, 3)

There is no uniform policy regarding composition and duties of Governing Boards and their relations to the administrative staff.

4. <i>Professional Policies</i>	Hospitals
Professional staff had a voice	21
Executive Committee of Staff only	10
Board and Staff combined	11
Determined by Lay Board	4

5. <i>Selection of Professional Staff</i>	
By Board	13
Board and Staff	22
Staff	2
City Commissioners	3
Bishop	1
Superintendent	1
Medical Director	1
Board has legal appointing power	31
Staff always consulted	36

Term of Appointment

Staff self-perpetuating	20
Appointed for life	3
Appointed to retirement at 65 years	2
Appointed for one year	29

6. <i>Staff (organization)</i>	
Organized	44
Not organized	0
Partly organized	1

Staff Meetings

Monthly	39
Bi-monthly	2
Weekly	1
Quarterly	1
None	1

CONCLUSIONS (Paragraphs 4, 5, 6)

There is no standardization of staff appointments and policies. The professional staff in many cases occupies only an advisory position in determining policies governing its own activities. Too often staff appointments are under political control.

7. <i>Staff Recommendations to Board</i>	Hospitals
Encouraged	40
Not encouraged	4
By written communication	30
Through Staff representative	24
Through Medical Director	3

8. <i>Staff Representation on Board</i>	
Chief of Staff is on Board	20
Elective Representatives on Board	8
Board appoints representative	15

CONCLUSIONS (Paragraphs 7 and 8)

There is insufficient contact between the professional staff and governing boards.

9. <i>Staff (types)</i>	Hospitals
Closed	29
Open	12
Courtesy	4

10. <i>Chief of Staff</i>	
Elected by Staff	22
By Board, recommended by Staff	2
By Board	11
By Staff on approval of Board	3
By Medical Director	1
Not reporting	7

CONCLUSION

The professional staff does not have sufficient authority in selection of its members in some hospitals.

11. <i>Medical Director</i>	Hospitals
Full time	6
Part time	16

Appointed by:

Board	9
Staff	4
Staff and Board	2
Pastor	1
Civil Service	1
Not stated	5

Term of Appointment:

One year	8
Three years	3
Indefinite term	8
Not stated	3

CONCLUSION

The definition of the title "Medical Director" is not clear. In some institutions he is an administrator. In some institutions his duties are purely professional. He is not always appointed or elected by the staff even when his duties are entirely professional.

12. <i>Internes</i>	Hospitals
Interne staff	30
No internes	11
Resident physician	13
Resident physician, paid salary	11

13. <i>Discipline</i>	
The procedure consists, in practically all cases, of a hearing before the Board, the Staff, or a meeting of both. Recommendation to expel a staff member usually originates from staff, actual expulsion carried out by the Board. Such action seldom necessary.	

Causes for expulsion:

Unethical conduct	
Neglect of duty	
Moral turpitude	
Ceasing to be a member of Medical Society	

14. <i>Anesthetist</i>	Hospitals
Physician as Chief	36
Nurse Anesthetists	19

15. Laboratory Facilities

- a. Availability for Private Out-Patients

Available	38
Not available	7
No laboratory	4
- b. Basis of Charge for Private Work

Varied and confusing—"ability to pay", "standard fees", "sliding scale", "half regular rate", "full charge", "schedule of fees".	
---	--
- c. Pathologist

Receives salary or fee	
Fee basis	8
No remuneration	19
- d. Charges for x-ray, physiotherapy, elec-
tro-cardiogram and metabolic tests
varied. Answers differed so widely it
is not possible to break the data down
accurately.

CONCLUSIONS

Although it is not clearly brought out in the survey, the Committee believes that the cost of laboratory, x-ray and other auxiliary services is excessive when rendered to private patients. In many cases, because of the excess cost, the private cases are denied the benefits of these services which are furnished ward cases free of charge or at minimum fees.

The extra charges for auxiliary services and special nursing service, when required, add a very appreciable burden to the cost of private room care. At times this burden is so great as to make efficient private room care beyond the reach of many private patients.

There is a lack of standardization relative to availability and charges for laboratory work.

RECOMMENDATIONS

MEDICAL DIRECTOR

That there be a common definition of the title "Medical Director", and of the title "Chief of Staff".

That the Medical Director, if his activities are those of "Chief of Staff", be appointed or elected by the Staff.

There should be a clear definition of the duties of each and their relations to administrative and professional functions.

STAFF RELATIONS TO BOARD

That the Staff shall be represented on the Board by a type of representation which is satisfactory to all concerned.

That definite channels shall be established by which any individual of the Staff may communicate with the Board.

That the staff members shall be appointed by the hospital board only upon recommendation of the professional staff.

That professional policies of the staff be determined by the staff.

That politics play no part in the appointment of staff members.

That all regular and courtesy staff members be members of their respective County Medical Societies.

That laboratory facilities be made available to private patients at a standard fee common to all hospitals within the price range adaptable to persons with low incomes.

That regular staff meetings of both In-Patient and Out-Patient staffs be insisted upon.

15. Pharmacies

	Hospitals
No pharmacy	24
Pharmacy (yes)	19
Profit (no)	18
Free prescriptions	25
Occasionally free	1
Free to needy cases	1
Free to venereals	1
Cost of free prescriptions—	
Charged to pharmacy overhead	12
Charged to hospital overhead	1
Charged to Special Social Service Fund	1

17. Pay Clinics (Not including those mentioned previously as charging to pay overhead.)

	Hospitals
Maintained by	4
Physicians paid for service	3
a. 50% of income	1
b. On definite salary	1

RECOMMENDATION

That no hospital conduct clinics for the profit of the hospital or physician.

That patients able to pay for physician's services be referred to private physicians.

18. Admission to Hospital

	Hospitals
On patient's request	15
On request of physician	46
From Out-Patient Department	39

19. Socio-Economic Service

Investigations made	29
No investigations	7
"Some" investigation	6
Accepted physician's statement	2

CONCLUSION

Socio-economic investigation is not well organized and is not at present effective.

RECOMMENDATION

This matter is of such vital importance to the social and economic welfare of all concerned that the Committee feels it must insist upon a complete investigation of social wel-

fare work with a view to establishing standard methods of investigation and determination of eligibility of patients by trained personnel whose opinion is not altered by emotions or sentiment.

20. Fees (Physicians' fees in Pay Wards)

	Hospitals
Permitted in pay ward cases	25
Not permitted	15
Permitted only for private cases	2
When hospital rate is above \$3.50	1

CONCLUSION

Physicians are not always allowed the privileges of the wards for private patients, even though the patient may be paying for hospital care.

RECOMMENDATIONS

That, where possible, the hospitals provide more facilities for private, pay ward cases.

21. Workman's Compensation Cases

	Hospitals
a. Admission	
Admitted to Wards	34
Admitted to Private Wards	1
Admitted to Semi-Private Wards	1
One hospital maintained Compensation Ward	1
Not admitted to Wards	6
b. Rate	
\$3.00-\$5.50 a day	46
c. Physicians' Fees	
Permitted (in liability cases)	40
Not permitted	2
Not permitted by physician on service ..	1
d. Dispensary Treatment of Compensation Cases:	
First treatment only	30
Emergency only	1
Full care	13
Full treatment at request of patient or employer	2
Hospital charging fees	27
Hospital charging for first treatment ..	3
Rate of charge varied	
\$5.00	1
\$4.00	1
Most hospitals charge \$2.00 a visit	
e. Attending Physician Remunerated	
Permitted to charge	16
Not permitted	14
f. Contract and Family Physician	
Family physician consulted before treatment is undertaken	10
Family physician not consulted	12
Replies from hospitals seem ambiguous or confusing	7
Contract physician permitted to treat patient if a member of staff	9
Contract physician not permitted to treat patient	22

CONCLUSIONS

The rates charged compensation cases is sometimes too low to pay "average cost per day".

In some instances hospitals are collecting fees for the professional care of compensation cases.

Attending physicians are not always permitted to charge for care of compensation cases.

Hospitals are not all observing the spirit of medical ethics in the care of compensation cases.

22. Free Service Rendered

The term "free service" applies to the physicians' services. Many hospitals collect variable amounts of money for service rendered by physicians.

Free service is reported as follows:

	Hospitals
Ward days 1,175,259 by	38
Dispensary visits 925,563 by	40
Free hospital and dispensary operations 48,910 by	27

CONCLUSIONS

The attending physician or surgeon receives no pay for his work and responsibility for the care of ward cases. It is an interesting fact that many patients receiving this free service feel, and some actually believe, that the physician is being well paid. This we have witnessed many times.

Here we wish to incorporate certain data from the "American Medical Association Survey of Medical Care in New Jersey".

The monetary value of free work by physicians in New Jersey is estimated to be about \$20,000,000 per year, or more than \$4,000 per physician capita per year.

These figures were obtained as follows:

In the A. M. A. Survey, detailed reports of one week's work during October, 1938, were received from 1182 physicians. They reported 17.2 per cent free office and home calls for a total of 16,070 for the week. The value of these calls was computed as follows: Allowing 10 per cent for physicians not in active practice or doing executive work, it is estimated that there are 4630 physicians in active practice in New Jersey; about four times the number reporting in the survey. The value of each call is \$1.00 per office call and \$2.00 per house call, or an average of \$1.50 per call.

Total calls for one week by 1182 physicians	16,070
	x 52

Calls for one year by 1182 physicians	835,640
	x 4

Total calls for one year by 4630 physicians	3,342,560
	x \$1.50

Value of free house and office calls	\$5,013,840
--------------------------------------	-------------

These 1182 physicians reported 1985 free operations during the week. On this basis, they performed 103,220 during the year. Applying the same figures to work of 4630 physicians and assuming the value of each operation to be \$25.00, the following results are obtained:

Operations—

1182 physicians performed in one week	1985
	x 52
1182 physicians performed in one year	103,220
	x 4
4630 physicians performed in one year	412,880
Assuming the cost of each to be \$25.00	x \$25
The value of free operations is.....	\$10,322,000

Dr. Frankel reported free ward and out-patient care in seventy-five general hospitals as follows:

Total free ward days	2,540,000
Total out-patient visits	1,500,000
At \$1.00 per visit the value is....	\$4,040,000

SUMMARY

Free house and office calls	\$ 5,013,840
Free operations	10,322,000
Free hospital and clinic calls	4,040,000
Total value of free service	\$19,375,840

With 4630 practicing physicians in the State, these figures indicate that each physician contributes over \$4000 in free service to the people of the State.

The value of free obstetrical care could not be included because of the incomplete figures submitted.

The number of free operations seems high, and indicate that approximately 10 per cent of these free patients were operated upon during the year. However, when we compare this figure with the figure used by insurance companies and voluntary health plans, which allow for about eight per cent operative procedures per year, our figure seems quite reasonable.

We feel that the above figures are a low estimate, with a resulting low estimate of the value of physicians' services, if such services can be measured on a monetary basis. What the figures actually represent is a low estimate of the contribution made by the physicians of this State for the care of indigent citizens who become temporarily wards of the State when illness overtakes them. It is socialization by individuals as always practiced and at present preferred by the majority of physicians as distinct from socialization under governmental control.

RECOMMENDATIONS

That physicians be protected from the abuse of free service in clinics by proper socio-economic investigations of all patients.

CONCLUSIONS RELATIVE TO ENTIRE SURVEY

This committee, believing that physicians are willing and anxious to contribute unsparingly of their time and services to any effort in behalf of the indigent sick, should be protected from any abuse of the services they render.

We believe that the general efficiency of all concerned would improve if standard policies and plans were adopted regarding the appointment and promotion of hospital and dispensary staff members.

We believe the rights and privileges of physicians in relation to the hospital management, administration and patient should be definitely determined and stated, upon a basis acceptable to all concerned.

RECOMMENDATIONS RELATIVE TO ENTIRE SURVEY

The Committee recommends:

1. That the general policies and plans regarding all phases of hospital management and administration, and their relations with the professional staffs and patients be established by a committee composed of representatives of the managing boards, the professional staffs, the administrative staffs, the officers of the New Jersey Hospital Association, and The Medical Society of New Jersey.

2. That these policies, when tentatively determined, should be widely publicized among staff members, board members, administrators, and county medical societies for the purpose of adopting satisfactory methods of administration and procedures.

3. That approved policies and plans to govern the administration of hospitals and the relationship of patients, physicians, administrators, and Boards be expressed by a Constitution and By-Laws for each hospital, or a definite written agreement adopted by the staff and board of each hospital.

SPENCER T. SNEDECOR,
Chairman

WILLIAM H. WARNER
HENRY B. DECKER
FLORENTINE HOFFMAN
E. W. LANCE
GEORGE O'HANLON
THOMAS K. LEWIS,
Consultant

May 31, 1939.

THE DOCTOR AND HIS WORKSHOP

By G. HARVEY AGNEW, M.D., F.A.C.H.A.

President, American Hospital Association, and Secretary, Department of Hospital Service,
Canadian Medical Association

An address before the Joint Meeting of The Medical Society of New Jersey and the New Jersey Hospital
Association held in Atlantic City on June 8, 1939

It is fitting indeed that every now and then we have joint sessions of the medical and of the hospital associations. Although working so closely together, it is surprising how few opportunities there are to discuss topics of mutual interest.

The practice of medicine is an ever-changing vocation. The relationships of the profession to those whom we serve, to the allied professions, and to the hospitals, are constantly changing. The present-day concept of what constitutes the field of medicine, of requisite educational preparation, and of adequate clinical and laboratory facilities, has undergone definite and radical revision during the past two or three decades.

The medical profession and the hospitals are steadily becoming more dependent upon each other. The time was when the average doctor, especially if he be a general practitioner, did not care very much about a hospital connection. He did most of his work in the office, or on the kitchen table of his patients; and, for that matter, his patients wouldn't think of going to the hospital anyway. Now, with the greater utilization of laboratory medicine in diagnosis, and with the necessity for elaborate facilities and organized teamwork to carry out the more complex surgical and other procedures, the whole picture has changed.

We now have the situation wherein our young graduates do not care to select a location lacking hospital facilities. A hospital connection means extra work; but it also means time and labor saved, results improved, reputations enhanced, and a spirit of scientific interest and enthusiasm kindled and preserved. Some specialties such as pathology and radiology may be practiced entirely in a hospital. Moreover, in larger centers an increasing number of doctors have their offices right in the hospital. The hospital is veritably the *doctor's workshop*.

STAFF PRIVILEGES

The medical profession and the hospitals have many points of common interest. For example, they are mutually concerned with offering to their patients the best possible service. Both desire that their patients reap the fullest benefit from modern equipment and scientific knowledge. Obviously *staff control* is of primary importance, for without staff control, both the profession and the hospitals are hamstrung in bringing about these results. This means *control of staff appointments* and, equally important, of the *type and quality of work done by the staff*. With this both the medical staff and the trustees of the hospital are deeply concerned.

There are still some in the medical profession who fail to realize that staff privileges are not a God-given right. Our license to practice by no means entitles us, ipso facto, to the luxury of working in a well-equipped hospital. That point has been settled at law.

There is an increasing realization that the privilege to practise in a hospital implies a very definite responsibility—a responsibility to do one's part to uphold the reputation of the institution, and, by implication, that of the medical staff as a whole; to coöperate with one's colleagues and with the administration in furthering the work of the hospital; to coöperate in the teaching of interns and nurses; to promote staff organization and welfare; and to assume one's share of the indigent work of the institution.

Acceptance of the chieftainship of a service is not an idle honor, to be celebrated by an indulgent and spineless tenure of office, or a prolonged trip abroad. This honor carries with it a definite *moral obligation* which may require tactful action, and sometimes distasteful decisions, and which may lead the conscientious chief or committee chairman to both mental worry and pecuniary loss.

CONTROL OF SURGERY AND SPECIALTIES

Ultimately one may anticipate, particularly in smaller centers, still stricter control by the profession of practice in specialties, or in major operative procedures in surgery and obstetrics. The specialty boards, developing under the stimulus of the *Advisory Board on Medical Specialties*, have done much to raise the standards in these fields. The public, apart from a somewhat indiscriminate preference for whom-ever calls himself a "specialist", has not been at all insistent, up to the present, upon adequate qualification. Ultimately one anticipates that public opinion will accomplish much in this respect. As you know, the poorest pauper in London would not think of exposing his peritoneum to anyone less than a Fellow of the Royal College of Surgeons.

DANGER OF TOO RIGID EXCLUSION

At the same time, one can carry this idea of exclusion of the rank and file too far. By virtue of the present-day necessity for access to the diagnostic and treatment facilities available only in hospitals, denial of such a large proportion of the practitioners in a community makes it exceedingly difficult for them to practise scientific medicine. Closure of such privileges to more than the incompetent, the rashly injudicious, or the unethical, will result in, has resulted in, the setting up and patronage of divers proprietary institutions. While many are excellent, it is unfortunately true that many others of these, particularly if they are not under medical management, are of the type where few or no questions are asked, records are not worth the paper upon which they may be written, and the patient has no assurance that the medical staff, such as it is, and the administration, are zealously guarding the quality of the work done. The records of the American Medical Association indicate that suits for negligence or malpractice are five times as frequent in unregistered as in the case of registered hospitals. Surely this means something.

From a community viewpoint, little is gained if much of the work is transferred to hospitals over which little or no supervision is exercised.

MEDICAL INTEREST IN ADMINISTRATION

In the second place, it would seem desirable that doctors take a greater interest in administrative matters. Most of the medical men in this audience are on the staff, I presume, of one or more of your local hospitals. If you are like most of the doctors whom I know, you have never had occasion to analyze the financial statement of your hospital. I doubt if many of the doctors present could state the exact cost per patient day for last year, or have ever visited the boiler plant, the laundry, or the kitchens.

Hospital administration has become a most complex and exacting vocation. It is fast becoming recognized as a profession. Several of our universities are now giving separate courses in hospital administration. Although open to laymen and nurses, as well as to doctors, hospital administration has become a distinct and highly attractive specialty in medicine. More of our young medical graduates might seriously consider the field of administration as a career.

My purpose at the moment, however, is to emphasize the desirability of greater understanding and sympathy between the clinical and the administrative sides of hospital work. With the increasing complexity of each, and the inevitable tendency to concentration of interest and viewpoint, there is a real danger of an ever-widening chasm between the two component groups, unless we seriously endeavor to bridge this gap.

EFFORTS TOWARDS COÖPERATION

Closer coöperation between the medical staffs and the administrative group is strongly urged. Keep the medical staff informed on administrative problems, on the costs of various items, on departmental losses and other details, by means of short talks at staff meetings, or by monthly letters from the superintendent or the trustees. Let the administration group explain why a new anaesthetic machine could not be purchased for lack of money, but ten times the amount was spent upon a new flat-work ironer in the laundry. Explain the costs to the hospital of delayed discharges, or of unnecessary laboratory work upon public patients.

And conversely, the trustees should be given repeated opportunities to obtain a more intimate knowledge of the medical viewpoint, concerning which, I have found, many trustees have a very inadequate conception.

Some hospitals endeavor to bring about a better understanding of the other fellow's problems by having joint luncheons or dinners once, twice, and three times a year. It is an experiment worth trying.

It has been my privilege to survey the staffing situation in a considerable number of hospitals, large and small, and I have come to the conclusion that most of the unhappiness and strife through which the hospital relationships of so many doctors are ruined could have been eliminated had they, or their colleagues, had a better understanding of hospital ethics, the difficulties of hospital finance, and the discipline and coöperation required of members of a hospital staff.

In an effort to minimize this situation in the future, a number of the medical schools, within the past few years, have arranged that the final year students be given a series of talks on hospital relationships. As a result, I am sure that these young doctors will be better, and more coöperative, staff members, and will live happier professional lives.

MEDICAL REPRESENTATION ON BOARDS OF TRUSTEES

In my own province of Ontario, the government has passed a regulation requiring that a representative of the medical staff of all voluntary and local governmental hospitals (i. e., non-profit and approved for the receipt of state aid for the care of indigents) shall be entitled to regular membership upon the board of trustees or governors. While this has been criticised and opposed by some trustees, I am firmly convinced that it has been a wise procedure. The doctors who make most trouble on the boards of hospitals are not those elected by the staffs, but are usually those holding membership for other reasons—political, for example, or as representative of a lay society, or a church.

SOCIAL INSURANCE

One of the burning questions of the day is that of health insurance and the socialization of medicine. On this general subject there are almost as many different views as there are committees, and even individuals. A few years ago we had the much-discussed majority and minority reports. A year ago the famous Committee of Physicians issued its protest against the orthodox medical viewpoint. Last month the American Medical Association issued twenty-two reasons for opposing the Wagner National Health measure. On the other hand, last week in my own province, the Ontario Medical Association declared itself definitely in favor of compulsory health insurance.

No matter where we stand individually on this question, we must realize that there is a definite trend in one direction. Not only have practically all other countries adopted in whole or part the socialization of their health services, but here, during the past two decades, so many of our health and social activities have become socialized, either under governmental or voluntary auspices, that we have already gone a long way in that direction. I have in mind particularly the care of industrial accidents, the care of veterans, hospitalization of indigents, relief provisions, old-age pensions, and what-not. Already millions are enrolled under hospital care insurance plans.

If there be this definite trend—and who can honestly deny it—is it not vital that we should make more effort than in the past to direct the outcome of this grouping, but apparently irresistible, movement towards the soundest and safest possible solution? Nothing is gained by refusing to face issues and airily denying the existence of any deep-rooted demand for change. Little is gained by criticizing and opposing the solutions offered by others, unless we can suggest something better.

It is more than ever essential that these two great groups—the doctors and the hospitals—work more closely together. They may have divergence of opinion with respect to detail, but the main objectives, the fundamentals, underlying our programs are, or should be, almost

identical. After all, both groups exist for one primary function—*service to the sick*. Granted that it is essential that we guard our self-protection, we must keep in mind that, when other objectives—personal or economic—are allowed to becloud that basic function, we cannot expect to retain public sympathy and support.

History was made last February when the Board of Trustees of the American Medical Association and of the American Hospital Association sat down together for a full day's conference. We hope that such valuable sessions can be repeated.

HOSPITAL CARE INSURANCE

If we take the sensible viewpoint that our present system, although excellent, is not entirely perfect, we can avoid drastic changes only by endeavoring jointly to find the most effective and least disturbing remedies for these weaknesses. Let us consider hospital care insurance as an example.

Hospital care insurance does not provide a panacea; but it does offer one means of minimizing the burden of hospitalization costs. With the help of the Commission on Hospital Service of the American Hospital Association, the less desirable features of the standard type of plan have been removed, and the plans have been developed to the point where they have not only proven their value, but have given us a clue to the solution of the economic factor in sickness. This movement has been opposed by some because it was looked upon as the thin edge of the wedge for compulsory state-controlled medicine. In the minds of many astute observers it should be regarded, on the other hand, not so much as a precursor but as a *pre-ventive* of more radical changes.

We may accept the principle as sound, but differ on the details. For instance, one could consider the question of whether or not radiological and pathological services should be included in hospital care plans. Should the demand of the subscriber and of the family doctor for the inclusion of diagnostic services in

these plans be followed, or should they be omitted, as has been requested by the radiologists in many centers? Is the employment of a radiologist or pathologist by a hospital on a salary or percentage basis a debasement of the medical profession or practice by hospitals, or should it be regarded simply as the practice of medicine by these doctors *in a hospital*?

We could get into endless detail, although perhaps the agreement reached some time ago by the radiological societies and the American Hospital Association with respect to financial arrangements would suffice. This was to the effect that any one of the accepted bases of financial arrangement might be considered the best for any particular situation, *provided neither party exploited the other*. The essential point, however, in discussing these developments, is not to permit matters of detailed or personal arrangement to becloud the main issue at stake. Radiologists and pathologists are perfectly justified in demanding fair compensation for any increased work, but the final criterion, as in all evolutionary or controversial features of the practice of medicine, will eventually be, *What is the best for the patient?* We must realize that neither hospitals nor doctors, nor any component group of such, can hope for the survival of any arrangement not conforming to this criterion.

If the principle of voluntary contributory insurance for those who can pay is sound, let us say so; let us get behind these movements, and endorse the principle; and then proceed to correct any details not to our liking.

In conclusion, let me emphasize that our professional and institutional futures would seem to be indissolubly bound. Let us plan now for a future which will permit the profession and the hospitals together to give to the people of this continent a service the like of which has never been possible before. Let us plan now for the place of the hospital—the doctors' workshop—in the health scheme of the future. Let us take the lead in working out that future. The ultimate solution rests in large part with ourselves.

GOVERNMENTAL PLANNING FOR HEALTH

By HAVEN EMERSON, M.D., Professor of Public Health Practice,
Columbia University, New York

An address at the General Session of the Annual Meeting of The Medical Society of New Jersey in Atlantic City, N. J., June 8, 1939.

Among the major causes of controversy and confusion of thought between persons with equal interest in their fellowmen, and accustomed to reach agreement by the process of conference and discussion, is a lack of precision in the use of terms, or failure to define the meaning of words or phrases upon which the substance and merit of an argument hang.

We of the medical profession, and our associates in the practice of dentistry, nursing, and pharmacy, not to mention the related bacteriologists, chemists, physicists and biologists, are at the moment at the mercy of slogans, of political catch-words, and of popular misconceptions which may easily prove our undoing if we do not ourselves declare our meaning and insist upon our own correct definitions.

STATE, OR PUBLIC, MEDICINE

First in importance seem to me to be the much-abused and overworked terms *state medicine*, *public medicine*, and *socialized medicine*. Care of the sick at taxpayers' expense, as carried out almost universally in this country for those recognized as unable to pay for necessary medical care, is of course *state medicine* or *public medical service*. If all the free medical service to the sick were in fact paid for out of the tax money, the cost to the taxpayers would be about twice what it now is. A large amount of institutional care of the sick is provided by general philanthropy. Services of much greater potential cost are supplied to the sick poor by the medical profession. Not only have we adopted and professionally participated in and officially approved of state or public medicine so far as it has been supplied to the sick who are unable to pay, but also we have recognized the necessity and entire appropriateness of the operation by local and State government, almost to the exclusion of private undertakings, of hospitals for acute communicable diseases, tuberculosis, and mental diseases.

All public health services carried on by local,

city, county, state, and federal governments are applications of state medicine. How otherwise could the police power of the state, its authority to conduct activities impossible for the individual physician to engage in, be effective except by the employment with tax money of officers charged with the enforcement of the public health law and sanitation codes?

Briefly then *state medicine*, or *public medicine*, is the provision by government, at the expense of the taxpayers, of services for the sick, and for the protection of the health of the people which can be better done, or be done at less expense, than would be practicable otherwise, or can be done only by the government as an exercise of its police function.

If it could be shown that better quality or a more nearly sufficient quantity of medical care for all people might be supplied by employment of all medical personnel at taxpayers' expense, there would be no logical basis for our opposition to such expansion of medical services to the exclusion of free initiative and private practice of medicine. This would be *socialized medicine* in the correct sense of the term.

SOCIALIZED MEDICINE

The term *socialized medicine* is perhaps more carelessly used, and with a general lack of understanding of its effects and implications, than any pair of words in current American medical affairs, unless it be the words *National Health*.

Socialized or nationalized medical services, correctly applied, describe a system of free medical care to all persons, by medical and other practitioners employed by government through the use of general tax funds. The three essential principles involved in socialized medicine are:

First, the universal availability of medical care to all persons within the political jurisdiction concerned.

Second, the employment of physicians as civil servants on a salary basis, as policemen,

firemen, school teachers and other civil servants are employed.

Third, the payment for all medical services, and the use of all institutional and auxiliary services, out of the tax funds without regard to the use of such services by any particular individual.

Governmental ownership of general or special hospitals, or employment of health officers, or salaries to local, county or city physicians for care of the sick poor, are to be found in effect widely here and abroad, and these are expressions of *state or public medicine in a restricted form*.

NATIONALIZED MEDICINE IN RUSSIA

Only in Russia has a nationalization of medicine been attempted,—that is, a socialized medicine in the true and correct use of this term. If anything worthy of scientific recognition or of practical economic or social approval had come out of the Russian experiment, there might be reason to consider an extension of our present limited application of state medicine to the unlimited use of socialized medicine which some enthusiasts would have us undertake. In reading the glowing eulogies of Russian health and medical care by the tourist authors, Sigerist and Kingsbury, one must bear in mind that neither of them has any background of experience or responsibility in administrative medicine. Before the World War, the famine, pestilence and revolution out of which the Russian Soviet have evolved, the average expectancy of life in Russia was similar to that of India today, or about twenty-seven years. Just prior to our Civil War, life expectancy in the United States was about forty years, and today it is just over sixty-two. It would not be a reckless hazard to prophecy that it will be a half century or more before there is in Russia the security of life such as we now enjoy in this country today. What will be our own achievement in 1989 would be pretty much of a guess; but seventy years of life expectancy is an entirely practicable goal. However, we are not now engaged in argument on the relative merits of socialized or nationalized medicine versus a limited form of state medicine with individual medicine as its background and support.

HEALTH INSURANCE

Of hardly less importance is the irresponsible, and often intentionally misleading, use of the term *health insurance*. Used to sweeten the bait, to mollify the taxpayer, to persuade the people they were getting something new and unusual, the term *health insurance* as it became widely known to English-speaking people, was introduced by Mr. Lloyd George, just as social insurance was used for similar purposes by Bismarck to steal the thunder of the increasingly powerful social political parties in Germany.

There is no such thing as *health insurance* on a state, national or commercial basis. In the very nature of things, health is a quality of human performance or achievement or adjustment which is not measurable or calculable in an actuarial sense. A person in obviously perfect health can at a moment's notice declare that he or she feels too ill to work, in fact has a conviction that health has left them and that compensation is due,—and no one, physician or other person, can prove the contrary. No commercial company, and no government, could conceivably offer an *insurance of health*. *Sickness insurance* there is or may be,—that is, a promise to pay for the cost of care in sickness, and also to pay for the loss of wages because of sickness.

In the mouths of the social promoters the term *health insurance* has an emotional, almost religious, significance. For sales talk it is conveniently vague; and to the public purchaser it has a tempting sound. Just think of it,—we are to pay little sums weekly or monthly, and shall have our health insured. Whereas the truth of it is that even to buy through an insurance system the average or even the minimum usual or necessary care for sickness will cost much more than the wage earner can pay. If by health insurance the promoters of this still wholly non-existent entity mean *periodic health examinations*, health guidance of mother and child for optimum development and growth, nutrition and marriage counselling, and child guidance in the psychiatric sense, then there will have to be double the proposed premiums.

INDEMNITY FOR LOSS OF WAGES

Let us avoid commitment to the unknown, and confine our concern to what exists, is practical, and has experience back of it, and is properly called *sickness insurance*, remembering however the distinction between insurance to meet the cost of medical care for sickness and its prevention, and *cash indemnity insurance* intended to maintain the wage earner's income during illness.

Sickness insurance, whether on the voluntary basis which is of ancient and honorable origin, or on a compulsory basis which has proved of doubtful permanent value and to be full of abuse both of government and the medical profession, as well as of uncertain benefit to the insured, can probably be established on an actuarially sound basis, if the essentials of characteristic sampling and sufficient size of the insured group can be assured.

HOSPITAL INSURANCE

Hospital insurance, or *group hospitalization*, is a relatively simple term as currently used, and is merely an insurance against the cost of an unpredictable, but occasional, high-cost hotel bill. Prepayment plans for hospital service are insurance schemes to meet the hospital's bill for board, lodging, routine nursing and the usual inclusive laboratory aids; but they do not include medical or surgical fees, or the cost of special nursing.

This is a distinctly American device to encourage thriftiness, to provide the self-supporting and self-respecting man or woman and the family with an easy way to set aside a small sum weekly, so that if hospital care is needed, the bill will be paid without further burden to the patient. Experience with more than sixty such schemes serving more than 3,500,000 persons in the United States shows that this form of voluntary insurance is *controllable* by insurance laws, is *sound* actuarially, is *acceptable* to hospitals, and is *endorsed* by physicians. There is nothing like it in other countries. This is probably the soundest and most useful form of insurance to meet social needs so far developed in the United States. While there are serious hazards of abuse, and the limits to its universal or state-wide or

nation-wide application are still far from determined, there are great advantages in its principle; and it is to be hoped that, with suitable adaptations, it can be made applicable to persons willing to accept ward care, as well as to those now enrolled who expect semiprivate room service. With suitable medical advice and participation in the direction of such plans, there seems no reason to doubt the certain benefits which are already apparent.

HOSPITALS, DISPENSARIES, AND CLINICS

To a medical audience it is hardly necessary to call attention to the differences between *group hospitalization*, and *group clinic practice*;—the one term being applicable to a group of potential patients associated for the purpose of insuring the payment of their individual hospital service bills by pooling their resources and thus spreading the occasional excessive burden of the individual among the many; the other term is descriptive of a group of physicians organized for professional collaboration, efficiency and economy of their offices and laboratories, to care for the individual or groups of persons seeking general or specialist medical advice.

In the hurry and thoughtlessness of our contemporary American life, we have almost lost the nice distinction between the *dispensary* and the *clinic*. With the entry of voluntary health and visiting nurse agencies, social workers and politicians into the medical scene, the term *clinic* tends to become generic for all types of out-patient care of the ambulatory client whether he is obviously sick, or is seeking guidance while in health.

The term *dispensary* is of early origin in Philadelphia, New York, and Boston; and this term is used in the statute law of New York and other states to describe an institution devoted to *out-patient care*, whether operated by a hospital, as an independent agency, or as an instrument of public health service.

The word *clinic* derives from the Greek word for couch or bed upon which the sick were examined by the priests of Aesculapius, and were there demonstrated and used for teaching purposes in the search for knowledge by the disciples. The term clinic as used in

Europe, and as, for example, applied to the Vanderbilt Clinic in New York, indicated a *teaching agency for clinical instruction*. This distinction or eminence set the clinic apart from the dispensary. Nowadays we have baby clinics, and clinics for every variety of general and specialist out-patient care; while most of them have all the disadvantages of the overworked and understaffed out-patient dispensary, and few if any have those characteristics which set aside teaching institutions in the medical sciences from the run-of-the-mill dispensary. Calling an *out-patient service* a *clinic* may save syllables, but it preserves no distinction in sense between the teaching and nonteaching dispensary.

ADMINISTRATIVE MEDICINE

In *administrative* medicine, as distinguished from individual or private practice of medicine whether primarily for care of the sick or exclusively for promotion of health, we are often confronted with the necessity of more comprehensive, more detailed, or more recent information as to the extent of sickness, its preventability, the resources for organized care of the sick, or health protection and promotion.

While vital statistics are useful to give us long-time trends in birth rates, death rates, and incidence of notifiable diseases, they are inadequate on the basis of any routine reporting to supply what we need to determine policies, and to plan for the future provision of institutions and agencies for sickness and health.

THE HEALTH SURVEY

For this reason a device as old as the Doomsday Book has been used for social purposes, the *health survey*, first used in this country in the classical undertaking in Pittsburgh in 1907, and later for a wide variety of particular needs in relation to important sanitary and health situations as well as for diseases of special significance. Under the name of *health and hospital surveys* a veritable library of documents has been accumulated upon the facilities, cost, methods, organization and results intended to promote health or to care for the sick. The Appraisal Form for city, county and state health work developed over the past fifteen years by the

American Public Health Association, and lately adopted in principle by the Health Section of the League of Nations, is probably the most comprehensive effort to offer criteria of health services and accomplishment. This has been used for comparative and competitive purpose by communities in large number in this country and Canada, and in various of the nations of Europe.

A *Health Survey* is a review and analysis, based on the facts of services for health, in relation to the health index or status of a population unit.

A *Hospital Survey* deals with the facilities for organized care of the sick in relation to the present and future needs of the community.

A *sickness survey* is something of an entirely different nature, and involves the discovery of the extent of all sickness, acute or chronic, or of the number of persons in a community afflicted with a particular disease on a given day, as by the case-finding surveys of tuberculosis, or crippled children, or the blind, or of the mentally afflicted.

It should not require more than average intelligence to use these survey terms with reasonable accuracy and with honesty of purpose.

We have been offered the rather pitiful exhibition, by the leaders of our Federal Government, of what they have called a *health survey* which dealt exclusively with the *search for sickness*. There has never been a national health survey in this country.

If there is to be in the years ahead a *national health program*, which I believe would prove to be but the grandiose and unreal imagining of people lacking in practical experience, it will have to be based upon a knowledge of the present resources for health, the functions of local and state health agencies, the personnel provided, the present cost, the results in terms of freedom from preventable disease and in better survival of infants, etc.;—and not on a counting of chronic invalids among the unemployed.

What has masqueraded under the term of *national health survey* was apparently conceived with the purpose of arousing emotion, of creating dissatisfaction, of developing a sense of class abuse, and of discrediting the accomplishment of philanthropy, of local govern-

ment, and of the medical profession. No new facts about disease or its prevalence or distribution were discovered. No evidence was obtained as to the causes of illnesses, the possibility of their prevention, the probability of their substantial betterment by medical care without a complete reconstruction of the economic, social, and educational lives of the sick discovered, and in some instances a control of hereditary factors. Even as a survey of sickness, evidently with the purpose of disclosing the extent of inadequate medical care, this much-exploited and analyzed study of disease made no attempt to learn and explain the reasons why medical care had not been obtained.

What possible faith can the people of the country place in a leadership and technical advisers offering something called a *national health program*, presented as if it were the result of a national health conference and supposed to be built upon the findings of a survey of disease, misnamed a health survey?

* * * * *

If a serious approach to the problems of sickness and health of the people of the United States were to be made under national auspices, it would in the first place deal with organized care of the sick and with facilities for health on a state-wide basis. There would then have to be an honest searching for neglected sickness, with an objective decision in each discovered case as to the practicability of effective medical improvement in the patient's condition, and the reasons for lack of its provision.

With these three factors,—services for the sick, facilities for health protection, and the extent and reasons for neglected illness—in hand, representatives of the professions concerned, and of official and voluntary agencies involved, and of the various economic and employment groups, should be asked to consider the evidence, arrive at their respective opinions at leisure and independently, and then assemble as guests of the Federal Government to arrive at general agreement by the democratic procedure of conference, negotiation, compromise, and give and take.

NATIONAL HEALTH

The two words, the *national health*, are full of the noblest implication, and carry with them some of the most inspiring hopes which we, as a people, have held to for a century and a half. We have found a way by personal, local, and state responsibility, by raising the quality and providing a sufficiency of physicians, by creating institutions for the sick with unequalled generosity, and by investing intelligently and at an ever increasing rate in the prevention of disease and promotion of health through public services,—by all these sound and successful means, to raise the national health to levels at the same time highly creditable and with upward trends which promise even greater improvement in the future.

At present there appears to me to be no evidence of a substantial nature that any of the methods proposed in the so-called *national health program* would, if put into effect, have a favorable effect upon the prevalence of sickness, or upon the amount and character of its care, not better accomplished by developing well-established and suitably related resources as we now know and trust them.

Our medical resistance appears to me to be wholly justified in opposing the proposal of pressure groups for social and economic upheaval in and out of government, who have little direct and only theoretical and remote experience to justify their demand that we turn over our medical concern and responsibility for the application of the medical sciences to them.

* * * * *

Government planning for health requires not only a critical and precise use of language, but an understanding of the basic factors in our form of government which have given stability and assured progress to the functions of public service.

The distinction of our growth in the application of the medical sciences for sickness and for health has come out of the dependence of both these upon the personal experience, observation and initiative of the individual general family physician. By his leadership, the interest and support of his fellow citizens have

been crystallized into action through local community organization by philanthropy or tax resources about equally.

Hospitals and health departments were developed in response to impulses of humanity, and out of intelligent understanding of the value of preventive medicine,—the one dealing with the sick individual, the other using authority and public resources to protect the whole community against pestilence and other preventable ills. Only after long intervals were local, village, and city health departments supplemented and strengthened by state health departments which now contribute much towards uniformity and adequacy of public care of the sick and of health, the state wisely in most instances leaving the largest share of responsibility, both financial and professional, to the smallest unit of local government which can support a full-time health service.

The Federal Government has until in relatively recent years wisely refrained from taking part in local health and medical services, exercising meanwhile its necessary functions as guardian of interstate and international relations to health.

* * * * *

There is no impropriety in the entry of a federal health organization into the field of surveying of medical care, or of services of preventive medicine. Even a moderate acquaintance with the sources of information, and with the complexity and infinite variety of conditions in our far-flung continent and among our 130,000,000 people, would persuade any conscientious searcher for the facts that the beginnings of information will everywhere be found in the experience of *local* doctors of medicine, visiting nurses, family relief agents, hospital dispensary and official and voluntary health agencies. By using such sources, competent constructive studies and resulting effective plans for improvement in care of the sick and in public health have been made in literally hundreds of cities and counties, but so far in no States in the Union more completely than in New York, New Jersey and Michigan.

FOUR STAGES OF FEDERAL PLANNING

It is not without a reasonable distrust in the objectives, methods, and policies that we find ourselves faced with four stages of federal planning, no one of which appears to have taken into consideration the best sources of fact or the great force of local autonomy and responsibility in medical services. Working backward to unravel or try to explain the sequence of events or documentary results of federal concern with the health of the nation, we have before us the four specific undertakings in the legal phraseology of the Wagner National Health Bill, the National Health Conference, the Technical Committee Report, and the National Health Survey.

The survey was of *sickness* and not of health.

The Technical Report expressed *generalizations* which shocked without convincing, and by extravagance of statement implied what was contrary to sound and informed opinion and experience.

The Conference permitted neither discussion nor agreement, but followed a pattern of organized propaganda which smacked more of salesmanship than of science.

The *Health Bill* thinly disguises a plan for distribution of wealth under the guise of pioneering for social reform.

If plans are to be made for national health which will enlist the coöperative wisdom and experience of physicians and patients, they must *begin* with a concern for the best quality of medical care which can be taught; and be *followed* by education of the laity to demand and use the best medical services which can be bought by individual and collective means. It is unlikely that any fantastic or extravagant project of federal spending or dominance of policies, functions, or personnel for care of sickness and protection of health on a national scale can be made effective while there is such extensive disturbance of the economic and industrial structure of the country.

THE DOCTOR AT THE CROSSROADS

By NATHAN B. VAN ETEN, M.D., New York City

President-Elect of the American Medical Association

Read before the General Session of The Medical Society of New Jersey at its Annual Meeting on June 6, 1939,
in Haddon Hall, Atlantic City, N. J.

"Medical service for all Americans", demands the propagandist for government administration, and supports his thesis by claiming that at present medical service is neither available nor willingly given.

The medical profession denies the truth of both of these statements.

The profession is numerically ample, its generosity is traditional, and approximately 20 per cent of all hospital beds are unoccupied from lack of sick persons to fill them.

Medical service for all the people has long been an objective of the American Medical Association.

Better medicine through better educated physicians is constantly studied by its councils. The Council on Medical Education and Hospitals promotes these ideals every day in the year.

There are people who *have no* medical care; there are people who *do not seek* medical care; there are others who *object* to medical care; and there are sick people who *do not know* how to find medical care. All these people must be surrounded by the protecting arms of the public health service.

The medical profession makes no claim to flawless service, but it is most unfair to claim that its members are making no progressive effort to improve it.

If American medicine is to go forward, it must welcome constructive criticism from whatever source; and every physician must be encouraged to express himself in the meetings of his county medical society where he will be heard.

Some of the criticism *from within* the profession seems to have come from physicians who have chosen to ignore this procedure and have sent their complaints through the public press. Criticism from *without* seems to have come from politically-minded people who style themselves experts in *social philosophy*. It is believed that few of them have had bedside experience.

MEDICAL ADMINISTRATION

The fact that most of the 113,000 members of the American Medical Association are trying to take care of sick people does not absolve them from valid charges that they are failing to take an active interest in broader fields of medical service.

How can this interest be stimulated? How many physicians are informed concerning the Washington Health Conference last July? Or the special session of the House of Delegates at Chicago in September? Or the current progress of the Wagner health program in the United States Senate? How many read their national and State Medical Journals with any interest in the social problems which vitally concern every one of them? How many physicians read anything in their Journals beside the articles which discuss the special problems which confront them in their daily practice? How many physicians read their Journals at all?

The physician reads his local newspaper and finds himself accused of something akin to criminal negligence. He senses a crisis in his professional life. Where shall he go from here?

He sits at the crossroads in great perplexity. He reviews with satisfaction his evolution from the early days when he was a barber or a servant of a wealthy patron, up to the time when he became licensed by society to practice healing arts, recognized, and respected because of his knowledge and ability.

Introspectively he is sorry for himself. His self-esteem has been hurt by investigative research and criticism of his effectiveness not only as a social agent but as a technician.

His education has been criticized, even his character has been assailed.

He has heard himself branded as reactionary, as a merchant of health, as a Robin Hood, as a dishonest fee-splitter, as a criminal abortionist, or as a cheater of insurance companies. His ethics have been reviled as mere facades.

He is unhappy because his income is shrinking, while he sees unnecessary invasion of his field by government agencies.

If he is an average man, he realizes that competition from his fellows is unnecessarily severe because too many are permitted to divide his opportunity. In spite of all such discouragement, he is generally ethical and seldom yields to temptations to escape from his distress by devious paths. He is still a member of the society of educated gentlemen, and he tries to justify himself.

He knows that the practice of medicine has greatly changed in the last twenty years. Preventive medicine has largely eliminated diseases which formerly absorbed much of his effort; and whether he likes it or not, he must cultivate new fields. He knows that biological results will always create new problems.

Adolescence, and senescence, and casualties, and malignancies will continue to engage his earnest thought, but his major function may possibly lie along the lines of *education*. Life has been externalized by science which has progressed from one objective revelation to another. Standards of living constantly change, and challenge deliberation. The doctor must not only study constantly to understand them and their effect upon the health of our citizens, but he must prepare himself for leadership of social currents so that they may become assets instead of perils to our civilization.

The hesitant doctor looks back upon the long uphill road which he has climbed; he looks ahead and sees only more difficult heights; he looks down into a valley of indecision. Will he slip into decadence? or will he become a fighter for whatever he thinks is right?

The relation of the physician to society assumes acute importance in the presence of experimentation under the aegis of *social security*. Extraordinary political changes in every part of the world, reversion in many countries from democracy to autocracy, tendencies to centralization of authority in the United States, and submergence of the individual in mass movements,—all these conditions are disturbing to practitioners of medicine who have been developed under the American tradition. American physicians must assume social leadership

if they would avoid the rôles of pawns in the hands of those who are playing the games of political strategy. Membership in a profession seems to have been regarded as an insulation against extra-professional contacts. Preoccupation with scientific interests has erected barriers to civic interest. Physicians have been called poor business men, and impractical idealists. Their sentimentalism has been exploited by professional welfare organizations. Without the gratuitous service of the doctor, many of these organizations would fail. So-called philanthropy is not dependable, but the physician will always work for the pay of prestige, and for the pay of applause, from the day of his graduation until the end of his life, probably always hoping that fortuitous circumstance will send him wealthy patients whose gratitude may assume a really valuable material expression. The physician himself is chiefly responsible for his precarious position. He has been so busy in his own kitchen garden that he has seldom looked upon the fields outside.

CLASSES OF PATIENTS

The practice of medicine is concerned with three classes of people,—the indigent, the large middle class, and a small group of people who may be called independently well-to-do.

All these people are better cared for in the United States than anywhere else.

A medical profession which includes large numbers of keen students has furnished striking advances in the last twenty-five years. Medicine has made extraordinary strides in epidemiology, in the therapy of diabetes, in the therapy of anaemia, in the therapy of orthopedics, in brain surgery, in chest surgery, in radiation therapy. Scientific methods have replaced empiricism.

Sick people in the well-to-do group may buy all forms of medical services in any amount. People in the large *middle group* may buy as much as they are able to pay for privately, and may avail themselves of elaborate hospital facilities at rates that range from maintenance costs to below-cost services.

People in the *indigent group* have access to hospitals which are supported by the taxpayer,

and also receive the benefit of the most approved therapy.

Each person may choose his own physician except those who seek free treatment in the hospital or clinic, where they must accept the services of the physician who may be assigned to the department.

There is very little criticism of the *quality* of medical care. The criticism concerns *distributions*; demands more *free medicine*; asks increased subsidy by government, meaning of course more help from the taxpayer; and looks to the implantation on the American people of some compulsory system such as one of those in European use.

Health insurance schemes abroad do not take care of the indigent, and have not reduced morbidity; but they have reduced the physicians to a very low place in the social scale. The present American system, however faulty, cares for all classes of people with very much better success.

If the critics would compare the failures of distribution of medical care with the failures of the distribution of education, housing, of clothing or of food, they would doubtless discover that they are talking about the same groups of people.

THE TAXPAYER

The care of the people is outside the field of insurance. It is the problem of the taxpayer. Medical service for these people is the job of the physician, and he must be paid for his work by the taxpayer.

Here is a task for the medical citizen. Let him step out of his professional seclusion, and let him participate actively in municipal affairs. Let him realize that preventive medicine may be greatly advanced by eliminating unsanitary housing, by feeding the undernourished, and by clothing those who are unable to so provide for themselves.

The taxpayer must be taught to realize that the facilities for medical care of the indigent are his responsibility, that free hospital service must be extended, and that perhaps the tax-supported hospital must assume all of this burden with both intern and extern service radiating from the hospital to home care.

It is not the task of the medical citizen to point out that under our present system, the landlord, the grocer, the clothier, house, feed and clothe the poor for *pay* only; while the doctor assumes their physical care in the hospital and in many homes without fee, and the landlord, the grocer, the clothier and other citizens expect him to continue this unfair sacrifice?

Let the municipality take over the hospital care of the indigent, use the facilities of the hospital for home care of the indigent; and let the doctors who are concerned with this care be paid for their services.

There are already less than 800 people in the United States for every physician, and the average annual sickness is less than seven days. About 2500 physicians die every year, while at the present time 7000 take their places. You see that the mathematics are stacked against the physician; and if he is to continue to prevail, he will need some very realistic hard work to support his idealism.

Another handicap is revealed in the studies of the Brookings Institute which showed that in 1929, a peak year, more than 42 per cent of American families received less than \$1500, and almost 60 per cent less than \$2000. Such incomes are a little *more* than subsistence requirements, and provide very small margins to cover the emergencies of sickness.

HOSPITALIZATION

Indices which cannot be ignored are the increasing dependence upon municipal hospitals by people who seem to need free care, the increasing demands upon physicians who serve these hospitals without pay, and the increasing financial embarrassment of the voluntary hospitals. Many hospitals deeply in deficits are surrendering their independence in return for municipal support,—an apparently inevitable trend.

Many hospital people who are unhappy over economic conditions think that they can cure situations by adopting service plans. Hospital service plans, now involving more than 2,000,000 subscribers, seem to be working well for the hospitals, and indirectly for the physician.

Intramural development of the hospital to

the highest degree will not bring it to its true place in our social structure. The day of exclusion and seclusion is past. Generous coöperation with all physicians and with social agencies must be developed. Hospital zones must be planned, and all competent physicians living within the zones must be permitted the use of the hospital's facilities. Individualism has been sneered at by welfare groups which are struggling for warm places in snug bureaus; but after all is said, and after studying all of the European service plans—which employ more lay managers than physicians, and which pay clerks more than doctors,—we must give tribute to the best traditions of this country which are based upon the individual care of the sick by the individual physician.

CIVIC ACTIVITIES OF PHYSICIANS

The American physician represents the most highly educated group of the community, but he functions too rarely as a *citizen*. How can the medical profession expect consideration from law-makers while the physician stands aloof from the actual exercise of citizenship? It seems more important than at any other time in our history that physicians should take positions of leadership in public activities, thereby indicating their willingness to coöperate to the limit of their abilities in the promotion of projects which seem to have community value. In order to be effective, physicians must have more than superficial knowledge of the machinery of government. They must function as citizens in the best sense of whatever citizenship means or implies.

The Doctor at the Crossroads must be revitalized.

MEDICAL PROBLEMS OF THE DAY

By ROCK SLEYSER, M.D., Wauwatosa, Wisconsin

President, the American Medical Association

Outline of an address before the General Session of the Annual Meeting of The Medical Society of New Jersey at Atlantic City on the evening of Tuesday, June 6, 1939.

Organized medicine in the United States has had a spontaneous development of 173 years, beginning with the establishment of The Medical Society of New Jersey on July 23, 1766, followed by the establishment of a similar organization in each of the other states, and in over one thousand counties, and culminating in the establishment of the American Medical Association in 1847. The objective of all these inter-related organizations has been concisely stated in the Constitution of The Medical Society of New Jersey to be—

“To render this profession most capable of serving humanity.”

But while these ideals have been consistently exemplified by the medical profession with a high degree of success, there has always been a lag in their acceptance by the people who have been deluded by specious promises of unscientific propagandists. For example, a century ago there was a widespread vogue of

Thompsonianism or treatment of all sorts of diseases by the use of native herbs. The basis of all the systems has been the desire to *receive* health, rather than to *achieve* it by following well-known rules of hygiene prescribed by scientific physicians. A people, formerly hard-working and independent, are now susceptible to glowing offers of governmental panaceas which are promised to them with no effort on their part. Simply accept the panacea of “State Medicine”, and sickness and ill health will be no more. With this panacea held before their eyes, the people believe that they can indulge in pleasures and excitement with a confidence that the “System” will perform miracles in delivering them from the effects of their own laziness and self-indulgence.

The fact is that the medical profession itself, voluntarily and from a sense of duty, is responsible for about everything “Social” in the practice of the healing arts today. How-

ever, we doctors have been so engrossed in our own good work that we supposed that public opinion correctly evaluated these benefits, and gave us the credit that was due to the profession. As a matter of fact, little credit is accorded to a profession which is giving a million dollars' worth of service daily in free service, and is rendering millions more at a cost to the recipients far below the cost of its delivery.

With a specious display of scientific accuracy, the Federal propagandists instituted a one-sided survey of the alleged extent of sickness by W. P. A. investigators who visited people in their homes and accepted their statements without any serious attempt at confirming them. As Dr. Haven Emerson has said: "In reality the 'Survey' was a drag-net hunt for chronic sickness. Furthermore, what was publicized as a *National Health Conference* was but a sounding board before a hand-picked group of invited guests.

"To describe the present state of the public health services of our country as *grossly inadequate* is a mischievous untruth, and expresses an emotional imbalance in the thoughts and experience of the technical committee members, unworthy of persons trusted with national statesmanship."

That some people who need medical attention do not receive it will always be true; but the dominant reasons are ignorance, superstition, and misinformation growing out of faith in advertised medicaments. In contrast with the grandiose plans of the Federal propagandists is the quiet investigation and planning which medical societies throughout the country are carrying on in two steps:

1. To ascertain the needs of each local group of people—in other words, to *make a correct diagnosis* of conditions in each community.

2. To develop in each community a service of practicing physicians coöperating with local officials, and each group performing its essential duty.

These two steps are those which are followed by physicians in their private practice. They are those which are followed by the medical societies of the counties, the states, and the national body—the American Medical Association.

These steps are also followed by official departments of health in dealing with preventable diseases.

This same system must be followed in relation to all other forms of preventable diseases and bodily depressions both physical and mental.

In all these discussions and proposals, the one outstanding result of permanent value is the stimulation of physicians throughout the country to evaluate their own services, and to develop the participation of the public in those services which special groups of citizens are unable to provide through their own resources.

The organized medical societies of the counties, the states, and the nation are now asserting their prerogative as the medical advisers of the governing boards and the welfare organizations of the local governmental units from the township and school district, up to the national officials. It is a process of friendly *evolution* in contrast with violent *revolution*, which is proposed by the Federal officials.

A LESSON FROM A DEATH CERTIFICATE

NUMBER TEN

Patient, aged forty years; central placenta previa with transverse presentation; seven months pregnant.

Slow labor. Voorhees bags used. Version with breech extraction. Severe hemorrhage and death.

Great danger of rupturing cervix in these cases as usually it is not fully dilated when the version is done.

Would not a cesarean have been safer?

A. W. BINGHAM, *Chairman,*
Maternal Welfare Committee.

THE COMMUNITY HOSPITAL AS A FACTOR IN IMPROVING OBSTETRICS

MATERNAL WELFARE ARTICLE NUMBER THIRTY-EIGHT

By ARTHUR W. BINGHAM, M.D., F.A.C.S., East Orange, N. J., Consulting
Obstetrician; and RAYMOND T. POTTER, M.D., F.A.C.S., Attending
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The Community Hospital is an important factor in improving obstetrics in the United States. By a Community Hospital is meant one in which any reputable physician in the community may attend his own patients, subject to supervision by a competent obstetrical staff.

The obstetrical staff must formulate routine *rules of procedure* which must be adhered to, except in special cases where a rule may be changed after consultation with one of the staff.

Rules for consultation in abnormal cases must also be enforced. These rules of procedure and rules for consultation should be *plainly posted* so that all physicians attending cases will see them.

As a means of educating the general practitioners and improving obstetrics, the Community Hospital has been somewhat neglected. Statistics presented here show that it is possible for a Community Hospital to obtain results comparable with those of any closed hospital. If the general practitioners are not allowed to attend cases in our best hospitals, they are obliged to use a nursing home, or keep the patients at home. In neither of these places is there any supervision, or is it easy to get a consultation.

When lectures are given, or obstetrical conferences held, the physicians who most need them are often not present; however, if they are allowed to attend their cases in a supervised hospital, they will follow its rules in order not to lose their courtesy privileges and in this way become acquainted with modern methods of procedure. Consultations are easily obtained with one of the obstetrical staff; and these afford practical demonstrations and are therefore educational. Advice as to what not to do is often as valuable as what to do. Consultations should be free unless the patient is able to pay for them.

Following is a report on the obstetrical service of the Orange Memorial Hospital for the period from mid-August of 1936 until May 15, 1939. It is chosen because, during these thirty-three months, we have had over 3000 deliveries without a maternal obstetrical death.

Ours is an "open" hospital to the extent that any physician granted courtesy privileges may care for maternity cases, subject to the rules governing this department. Each year, during the period of this computation, an average of eighty-one doctors, not including the hospital internes who are under direct supervision of the obstetrical staff, have delivered patients in the hospital.

Of the 3020 deliveries, 1894 were normal. There were 114 medium forceps, and 798 low forceps applications.

Caesarean section was performed 53 times, an incidence of 1 to 57. The indications for this method of delivery are shown in Table 1.

TABLE 1
INDICATIONS FOR CAESAREAN SECTION

Contracted pelvis	18
Flat pelvis	3
Disproportion between fetal head and maternal pelvis	7
Placenta previa	10
Breech presentation, elderly primipara	1
Preëclampsia	4
Premature separation of placenta	1
Uterine fibromyomata, obstructing birth canal ..	1
Uterine inertia	1
Gall-bladder disease in primipara with borderline pelvis	1
Ovarian cyst obstructing birth canal	1
Previous Caesarean followed by suppuration of wound	1
Cardiovascular disease, 46-year-old primipara...	1
Unprogressive labor with no dilatation of cervix	2
Face presentation	1
	<hr/> 53

There were 154 breech deliveries, seven versions, five cases of eclampsia and forty-six diagnosed as toxemias. The last-mentioned include patients with **hypertension only**, some with hypertension and albuminuria, and some definitely preëclamptic.

Premature deliveries numbered 105. There were twenty-three cases of placenta previa delivered by the normal route, and seventeen with premature separation of the placenta. Hemorrhage occurred in thirty-six instances, twelve of which were ante- or intrapartum, and twenty-four postpartum. Labor was induced in thirty-eight cases. Thirty-two deliveries resulted in twin births. Episiotomy was performed on 971 patients.

There were sixty-one stillbirths. Of this number, seventeen were six months or under; three were seven months; and two were hydrocephalic monsters.

Neonatal deaths numbered forty-six. The months of gestation at which these deaths followed delivery are shown in table 2.

TABLE 2

MONTHS OF GESTATION AT TIME OF NEONATAL DEATHS

5th Mo.	6th Mo.	7th Mo.	8th Mo.	Term
5	5	15	1	20

The physical status and general well-being of patients during their stay in the hospital is indicated by their morbidity. In determining morbidity, we have used the accepted standard of 100.4 degrees of temperature on two or more successive days exclusive of the first day postpartum. Omitting Caesareans from this group, of the 2967 remaining patients, forty-four, or 1.4 per cent had some morbidity. The total number of days' morbidity for all forty-four patients was 143. Expressed in terms of days' morbidity in relation to the

TABLE 3

Causes of Morbidity	No. of Patients	Total Days
Sapremia	5	15
Upper respiratory infections, colds and gripe	6	13
Pneumonia with breast abscess	1	18
Pyelitis and cystitis	8	30
Engorged breasts	7	14
Retained membranes	1	2
Syphilis	1	3
Endometritis	1	8
Possible G. C. infection	1	2
Infected perineum	2	8
Retained blood clot	1	3
Following transfusion	2	6
Salpingitis	1	2
Eclampsia	1	3
Undiagnosed	6	16
	44	143

total number of hospital days, the percentage morbidity was 0.36 per cent. Table three shows the causes of the morbidity, the incidence of each, and the total number of days involved.

Morbidity following Caesarean section occurred in sixteen of the fifty-three patients so delivered. The longest duration of temperature elevation occurred in one patient who had a low-grade intrauterine infection and a breast abscess. It lasted twenty days. The average morbidity of all sixteen patients was 4.2 days.

Abortions among charity or ward patients are under the jurisdiction of the obstetrical department. Private patients are treated by their own doctors. Neither of these classes of patients are housed nor treated in the maternity building.

During the years 1936, 1937, and 1938, 272 abortion cases were treated with no deaths. Twenty-one were classed as threatened; nineteen as inevitable; 192 incomplete; and forty complete. Under proper precautions, we do not hesitate to curette abortion cases when indicated, and our experience leads us to believe patients do better, their hospitalization is shortened, and they have fewer complications. Septic abortions are treated conservatively. The alcohol drain, as suggested by Dr. Edward J. Ill, is used frequently. Many are transfused. Curettage was performed on 211 patients who had abortions.

Tubal pregnancies are mentioned since they are a part of maternal mortality statistics. There were eighteen of these,—ten ruptured, and eight unruptured,—on whom laparotomies were performed. There were no deaths.

One reason for this good record is the comprehensive system of prenatal care as carried out by the Maternity Center of the Oranges and Maplewood, of which this hospital is a part.

ORGANIZATION OF AN OBSTETRICAL DEPARTMENT

In planning and organizing the obstetrical department of a Community Hospital, several points should be considered.

1. *Isolation from other patients*, preferably in a separate building. A detached building is the ideal arrangement. The private rooms and

wards must be isolated from other departments. The delivery rooms should not be in the same unit with the operating rooms as is frequently planned,—they should be in the obstetrical department, entirely away from surgery. They should be in a group with labor rooms separated from the private rooms and wards by sound-proof partitions. The hospital which treats maternity cases in close proximity to other patients is not giving the patient a fair chance. It may be a question of finances, but the necessary funds can usually be obtained if the public is acquainted with the need.

The nursing staff must be separate, and the nurses in other departments should not be allowed to visit the obstetrical unit.

2. *Supervision* of the department by a competent obstetrical staff.

3. *Standard routine procedures* to be adopted by the obstetrical staff and followed by all physicians attending cases, both ward and private. So many obstetrical cases are normal that routine procedures can easily be carried out. They greatly facilitate the nursing efficiency, and make it possible for a nurse to care for more patients. The procedures should be plainly posted on each floor so that attending physicians may see what is being carried out. The patients appreciate that there is less friction when routine methods are used. Of course in special conditions special orders may be given.

4. *Consultation in abnormal cases* should be required. This is a very important provision. If each physician is going to treat his abnormal cases as best he can without advice or assistance, progress will be very slow indeed. Under the protection of the hospital he will undertake procedures which he is unable to carry out without disastrous results. For the sake of maternal welfare, petty jealousies must be put aside, and a helping hand given to any physician who needs it in an abnormal case. When once this custom is established, there will be very little trouble in enforcing the rule.

5. *Provision for isolation of infected cases.* If a case is infected on admission or becomes infected, it must be taken from the obstetrical department unless in a larger hospital there is

a special place provided for such cases. As a rule, it is safer to move the patient to the general medical or surgical department to avoid contamination of the normal obstetrical patients. There should be a special isolation nursery with cubicles for babies with sore eyes, syphilis, impetigo, or other infections. They should be attended by special nurses, wearing a separate pair of gloves for each case; and gowns as well as masks should be worn by all entering this nursery as in other nurseries.

6. *Adequate records* should be kept in order to study cases and tabulate results in the annual report. The record sheets should be concise, but containing all the essential information. If the records are too complicated, it will be difficult to get the courtesy staff to fill them out properly. If a physician is not willing to keep a reasonable record, he should be denied hospital privileges. Records should not be filed away until they are completed. Internes should not sign maternal death certificates. Every hospital should make out an annual obstetrical report so as to properly evaluate its results.

7. *Obstetrical staff conferences* should be held regularly, and be open to all physicians interested. Monthly conferences are most valuable, as there details are discussed regarding causes of complications, how to prevent them, and how to treat them, as well as reasons for maternal deaths. Any physician may occasionally make an error in judgment or technic; but if he attends such conferences he is less likely to do so. Attendance in some hospitals is made obligatory for the courtesy staff as well as regular staff members.

8. Prenatal clinics should be a part of a comprehensive community system of prenatal care. The hospital which treats in its clinic only those cases which are to be cared for in its ward, is only partially doing its duty to the public.

This is the set-up of the Orange Memorial Hospital, and is the plan which is urged for general adoption by the Committee on Maternal Welfare of The Medical Society of New Jersey.

IMPETIGO CONTAGIOSA TREATED WITH AMMONIATED MERCURY-COLLOIDAL KAOLIN LOTION

By ARTHUR G. PRATT, M.D., Camden; ROBERT E. IMHOFF, M.D., Moorestown;
and HENRY B. DECKER, M.D., Camden, N. J.

From the Department of Dermatology of the Jefferson Medical College, Philadelphia, Pa.

The invasion of the skin by staphylococci or streptococci usually results in either a pustule or a cellulitis. Probably a *break in the epidermis* is necessary to enable these organisms to produce such lesions. When impetigo is encountered, however, the pyogenic organisms appear to have the ability to form their characteristic lesions on *unbroken epidermis*. A vesicular response follows when the secretion from such an eruption is placed in contact with selected clear skin. The contents of this vesicle contain both bacteria and an agent that is capable of reproducing a similar lesion on further contact. This vesicant agent may be of bacterial origin, or is a substance resulting from protein disintegration. The vesicle of impetigo is thin-walled and readily broken; and as the exudate dries, it yields a friable honey-colored crust. This crust is more firmly attached in the center; and when its lifted edges are present, it gives a "stuck-on" appearance.

ACTION OF COMMON REMEDIES

Of the fairly numerous remedies in common use, *ammoniated mercury* is the most widely accepted. This drug is definitely bactericidal, and is effective if precautions are taken against transferring the vesicular contents to new areas. Usually applied as an ointment, its oily nature does not permit it to mix with the serous liquid of the vesicle; and the result is that the exudate oozes through the ointment, and is likely to be transferred to new areas.

Ellison¹ has called attention to the fact that impetigo does not always yield readily to treatment. Some cases required five or six weeks' attention when orthodox ammoniated mercury

ointment was employed. O'Donovan² said that mercurial ointment of any potency causes dermatitis. Reed³ and Swendson and Lee⁴ considered ammoniated mercury ointment useless. On the other hand, Finnerud⁵ believed that in the mercury group was found the treatment of choice. He said that a regime including bathing the parts twice daily with warm mercury bichloride solution, applying a calomel dusting powder during the day, and a three to six per cent ammoniated mercury ointment at night, would cure practically any case of impetigo within five to ten days.

Antiseptic dyes such as mercurochrome, gentian violet,¹⁰ acriflavine¹ and malachite green² have been used. Calomel dusting powder,^{4,5} tannic acid,⁶ and silver nitrate solution have also been proposed; and these agents, besides being antiseptic, probably act to coat the ruptured vesicles and prevent the spread of the eruption. Carpenter,⁷ when comparing two per cent ammoniated mercury ointment and a compound chlorhydroxyquinoline ointment, obtained excellent results with both remedies. Occlusive dressings have been advocated by Newman⁸ and Hollander and Hecht.⁹ The main objections to these last are that they cannot be used in all locations, and that the patient, frequently a child, must refrain from removing or picking at the dressing.

The ideal remedy is one which is, first, bactericidal without being injurious to the normal skin; second, miscible with the vesicular liquid in order to permit an adsorbing agent to fix the vesicant element of the exudate; third, able to form a firmly adherent crust until the lesion is healed; and four, easy and simple of application.

In an attempt to meet these requirements, one of us (R. E. I.) proposed to combine an effective antiseptic, ammoniated mercury, with colloidal kaolin, which is capable of adsorbing bacteria and virus, in a gel of aluminum hydroxide. This mixture is miscible with the vesicle contents, and dries to form a firmly adherent crust. Such a preparation containing five per cent ammoniated mercury was made for us by John Wyeth and Brother, Inc., and supplied for the following tests.

CONTROLLED EXPERIMENTS

From May 1 to November 1, 1938, all cases of impetigo seen at the skin clinics of the Cooper Hospital, Camden, N. J., and the Jefferson Hospital, Philadelphia, Pa., were treated with the test lotion. For control cases, all the patients having impetigo admitted to the Skin-A Clinic at the Pennsylvania Hospital, Philadelphia, were treated with an ointment containing ten grains of ammoniated mercury and two grains of yellow oxide of mercury in one ounce of petrolatum. This ointment has been standard treatment for impetigo at that clinic for many years.

These hospitals were used for three reasons: first, the similarity of clientele with regard to

race, nationality, and economic standing; second, a medical staff common to the institutions could oversee all the patients; and third, each clinic had available a social service worker. It was known by experience that these patients were difficult to properly control. Without the follow-up activities of the social service worker, few of the patients would return when the eruption healed.

RESULTS

The total number of cases seen is given in table I. Of the total 144 cases, thirty-three were discarded because of our inability to follow the case until healing was complete. Some of the patients gave fictitious names and addresses, and failed to return. A few were impatient with their progress and voluntarily changed the treatment.

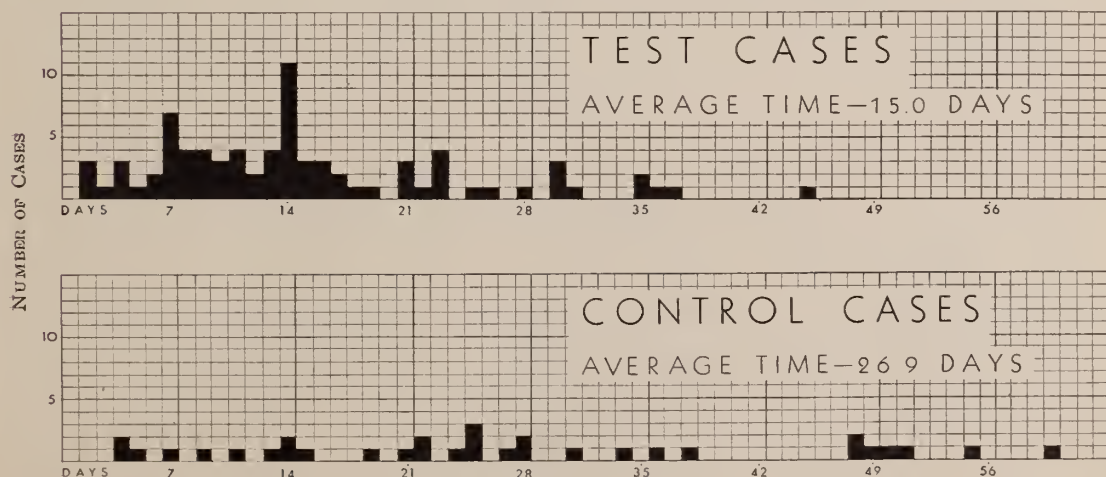
TABLE I
NUMBER OF CASES

	Total	Discarded	Used
Test Cases			
Jefferson Hospital	40	13	27
Cooper Hospital	58	6	52
	98	19	79
Control Cases			
Pennsylvania Hospital	46	14	32
Total	144	33	111

CHART I.—TIME REQUIRED TO HEAL THE CASES

Test cases, 79 in number, were treated with the special lotion of ammoniated mercury and kaolin.

Control cases, 32 in number, with ammoniated mercury ointment only.



TIME REQUIRED FOR HEALING

The time required to heal the cases is shown in Chart I. By healing time is meant the time required for every crust to become detached and replaced by dry, smooth epithelium. It will be seen that over half the test cases (62 per cent) were cured in two weeks or less; while only 28 per cent of the controls were healed in that time. The average time for the

test cases was 15.0 days; while 26.9 days were required for the controls.

The histories were studied to see if the number of lesions affected the healing time. It was found that there was no relation between the number of lesions and the time required to effect a cure. This is shown graphically in Charts II, A, B, and C.

CHART II, A.—COOPER HOSPITAL

Average time required for cure, 17.4 days; one case required 45 days

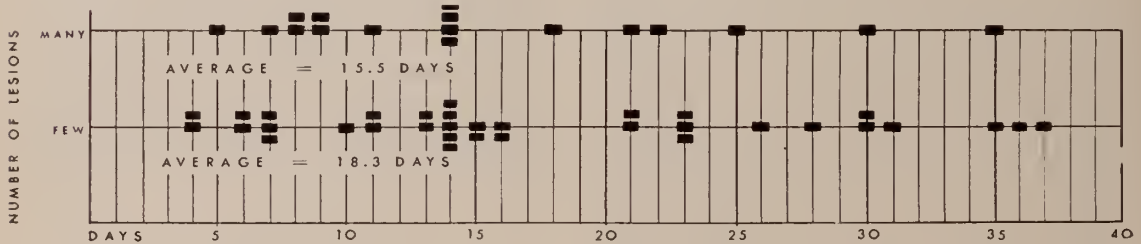


CHART II, B.—JEFFERSON HOSPITAL

Average time required for cure, 10.5 days

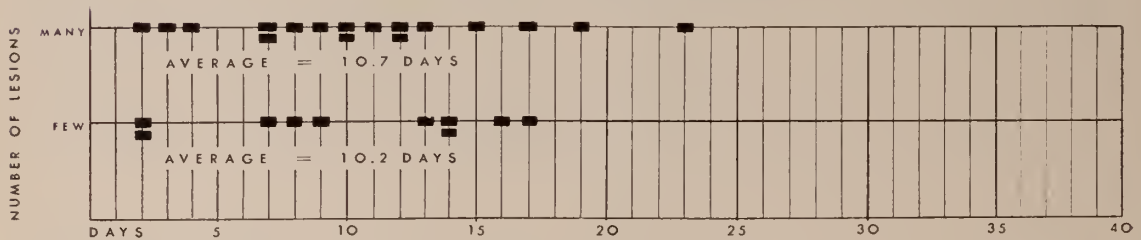
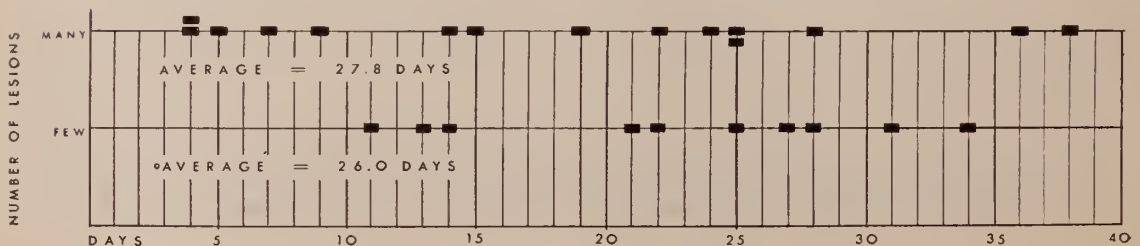


CHART II, C.—PENNSYLVANIA HOSPITAL

Average time required for cure, 26.9 days; seven cases required from 48 to 60 days

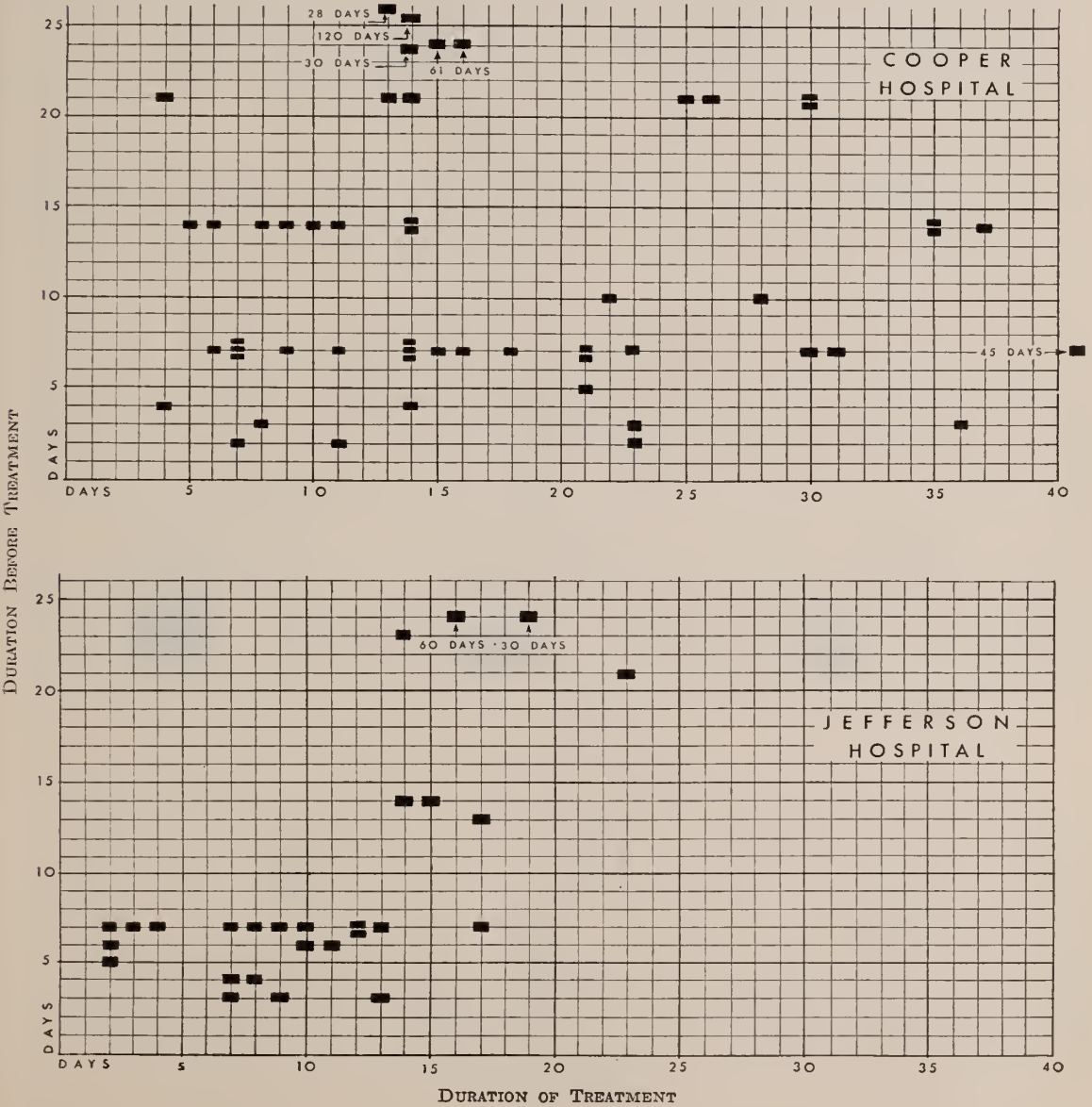


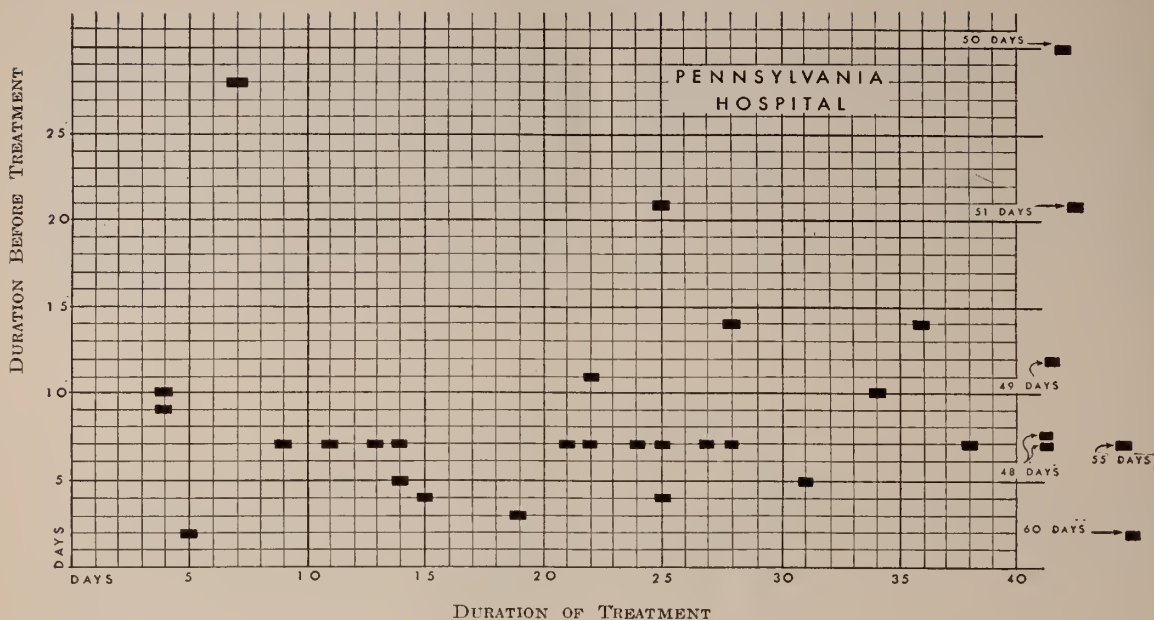
DURATION BEFORE TREATMENT

Our next thought was whether the duration of the condition previous to our treatment had any bearing on healing time. Chart III illustrates that the person with a long-standing eruption may heal just as quickly, or even more rapidly, than a fresh case. The reverse was also true. In other words, there was no relation between duration previous to treatment and time required to cure.

One result which we did not anticipate was the variation in average healing time between the two hospitals, Jefferson and Cooper, which were using the same method of treatment. Although the gross average of the test cases was fifteen days, the average time (shown in Chart II) to cure the twenty-seven cases at Jefferson Hospital was 10.5 days; and the average time to cure the fifty-two cases at Cooper Hos-

CHARTS III, A, B, AND C





pital was 17.4 days. In an attempt to find an explanation for this variation, the case histories were studied with respect to race, age, and economic status. It was found that these

factors had little or no bearing on the time that was required to cure the cases. This fact is shown in Charts IV, V, and VI.

CHART IV.—RACE

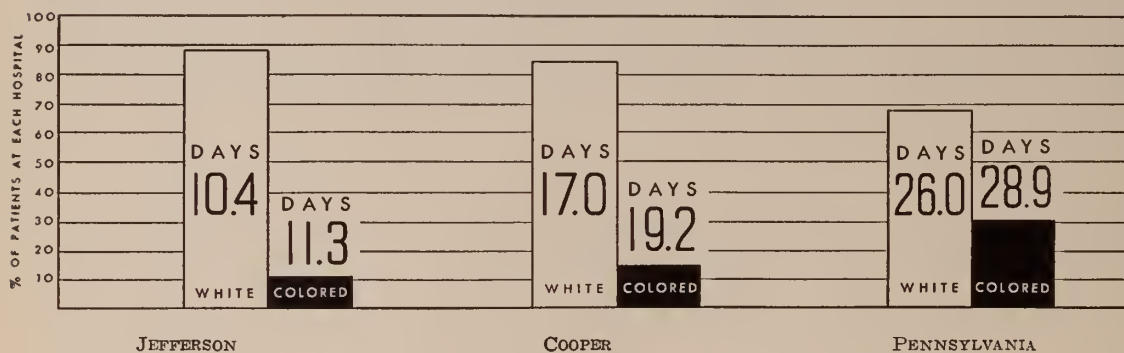


CHART V.—AGE

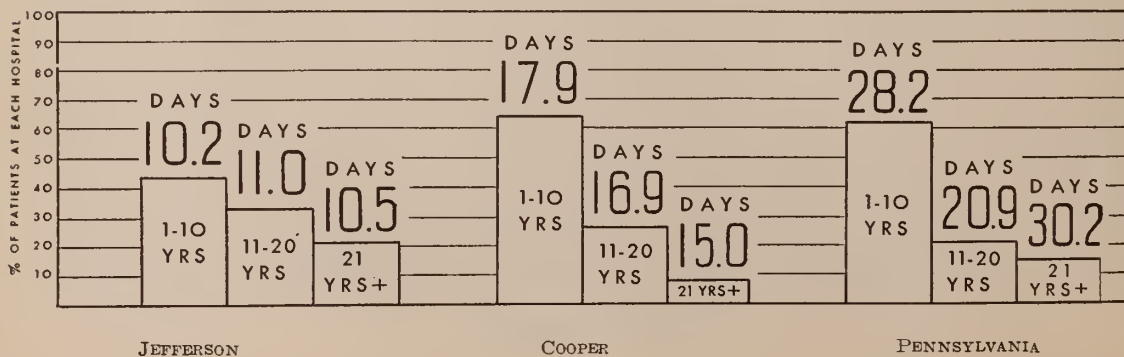
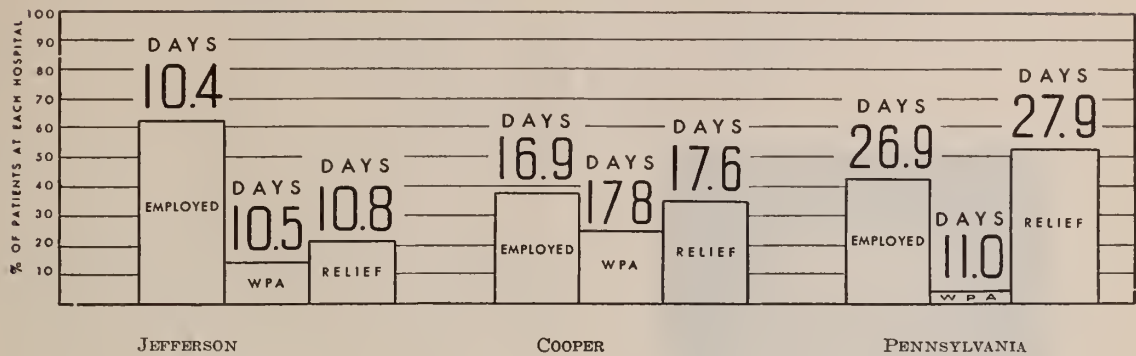


CHART VI.—ECONOMIC STATUS



Our only explanation of the difference in healing time between the Jefferson Hospital and Cooper Hospital cases is the personal factor. At the Jefferson and Pennsylvania Hospitals each new patient, after being diagnosed and prescribed treatment by the physician, was seen immediately by the respective social service worker. These attendants were trained nurses. They repeated the physician's instructions, and made certain that the patient, who is all too often confused by the atmosphere of the busy clinic, understood exactly what to do and knew when to return for observation. At Cooper Hospital approximately half the cases were not seen by the social service worker at the first visit. We had hoped that the sim-

plicity of the treatment with the lotion would counteract the difference in supervision, but evidently it failed to do so. On the other hand, it should be noted that the Cooper Hospital cases, although making a poorer showing than the Jefferson Hospital cases, averaged only 17.4 days to cure while the Pennsylvania Hospital cases using ammoniated mercury ointment averaged 26.9 days to cure.

CONCLUSIONS

An ammoniated mercury lotion containing colloidal kaolin to adsorb the vesicular exudate and form a firmly adherent crust is more effective in curing impetigo than ammoniated mercury ointment alone.

This work was made possible and the test material was supplied by John Wyeth and Brother, Inc.

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STATE SOCIETY ACTIVITIES

DR. EDWARD ZEH HAWKES



DR. EDWARD ZEH HAWKES
PRESIDENT, THE MEDICAL SOCIETY OF NEW JERSEY

Dr. Edward Zeh Hawkes, the 155th President of The Medical Society of New Jersey, is a native of Schenectady, N. Y., where he was born on October 20th, 1865. He is the son of Edward H. Hawkes and Jane Zeh Hawkes. The father was born in Bath, England, and at the age of twelve years ran away from home, came to the United States, and finally located in Schenectady. Jane Zeh Hawkes, his mother, was born in this country.

His preliminary education was obtained in the public schools of Schenectady, and in the Union Classical Institute of Schenectady. He graduated from Union College in 1887, receiving the degree of A. B. He then entered the College of Physicians and Surgeons of Columbia University, where he graduated in 1890 with the degree of M. D. In 1930 Union College conferred upon him the degree of Doctor of Science.

Dr. Charles Zeh, an uncle, was a prominent physician of Essex County, where he practiced for over fifty years; and through his influence

the citizens of Essex County received the benefits and influence of his nephew.

Dr. Hawkes married Mary Everett Hawley, daughter of Dr. Augustus Hawley, of Red Wing, Minnesota. They had three children, Jane Hawley, who lives at home with her father, and was present at the Annual Meeting of the Society; Mrs. F. Ballard Williams, Jr., of Glen Ridge, N. J.; and Dr. Stuart Zeh Hawkes, of Newark, N. J., who shares the office of his father.

The professional attainments of Dr. Hawkes have been recognized by many professional and civic organizations of Essex County, and the City of Newark. He is gynecologist to the Newark City Hospital, Medical Director of the Presbyterian Hospital, Chief of the Department of Surgery of St. James' Hospital, and Consulting Surgeon to Beth Israel Hospital and other hospitals.

He has taken an active part in the activities of the Medical Society of Essex County, and the Academy of Medicine of Northern New Jersey, and is an ex-President of both of these organizations. He has for years occupied positions of trust and honor in The Medical Society of New Jersey, and in 1936 was elected to the position of Second Vice-President. From this position he passed through the chairs of office to the position of President, to which he succeeded on June 8, 1939. He is a member of the Board of Trustees of the Society for the Relief of Widows and Orphans of Medical Men of New Jersey, and is a Trustee of his Alma Mater, Union College.

He is a member of the Essex County Country Club, and the Lake Placid Club, and plays golf for recreation.

With this background, training, and history of accomplishments, Dr. Hawkes is eminently fitted for the honor and duties of the office of President of The Medical Society of New Jersey, which has been ably filled by a long line of 154 eminent predecessors.

PRESIDENT'S INAUGURAL ADDRESS

By EDWARD ZEH HAWKES, M.D., Newark, N. J., the 155th President of
The Medical Society of New Jersey

Delivered before the House of Delegates, June 7, 1939

The founders of The Medical Society of New Jersey stated their purpose in organizing to be the interests of the profession and the welfare of the public.

During the succeeding 173 years, the science and the art of medicine have made enormous advances. Still the ideal of our profession today is exactly as stated by the founders,—“That we may better be able to serve mankind.”

It would seem that the years spent in trying to understand the nature of disease, and the daily contact with the sick, and the striving to lessen suffering and to restore health—it would seem that this constant striving for the welfare of others tends to transform practitioners of the healing art into public benefactors. I do not mean that we physicians have become saints, but I do insist that physicians who spend their lives in the actual practice of their profession are better and nobler men and women, because of the reaction of their daily experiences upon their characters; and that the world is better for their living in it. Even the worst of us is a better man by reason of being a physician.

Nearly two thousand years ago the founder of a great religion urged mankind “To love one's neighbor as one's self”.

But five hundred years before the Christian era, Hippocrates was practicing and proclaiming the principles of the Sermon on the Mount, as the result of his life devoted to healing.

The Hippocratic Oath has come down the centuries as the only unchanging philanthropy. While all sorts of persecutions and atrocities have been performed in the name of some form of religion, the Hippocratic Oath has always and unalterably proclaimed and practiced humanitarianism. To it there has been no heretic, no unfit, no outcast. All alike have been beneficiaries of its philanthropy. The

torch has burned with undimmed brightness for nearly twenty-five hundred years.

We in 1939 carry the torch handed on century after century. The Oath today continues to have all of the sanctity given to it by Hippocrates. It is still held high, guiding our way.

It is still the ideal for the relations between the physician and his patient. It is the ideal for the *individualistic* practice of medicine; and yet it makes no mention of the welfare of the *whole* people. But the founders of The Medical Society of New Jersey added new brilliancy to the torch. Its beams are now brighter and radiate wider. The founders stated their purpose to be the interest and uplift of the profession and the welfare of the public. Today we have expanded the scope of these briefly stated objectives, so that they apply to many activities. We are now interested in every phase of public health welfare, beginning with care for the unborn child.

These objectives are either purely in the interest of the public, such as the activities of the committees for child health, tuberculosis, cancer control, maternal welfare, crippled children; or they are for the benefit of the people and of the medical profession jointly, such as activities of the Committee for Medical Care of the Indigent, and of the Committee for Voluntary Health Insurance. We have no objectives that are contrary to public welfare.

Nevertheless the results so far realized are disappointing. Much thought and effort have been spent by us, largely preliminary and preparatory, without many satisfactory accomplishments. Although we ourselves know our purpose to be altruistic, the public often misunderstands, misjudges, and suspects us. When we propose a law or a policy which we tell the people is in their interest, the public nevertheless suspects that we must have some carefully concealed, purely selfish, purpose.

They cannot comprehend that we are actuated by motives other than those of pure business.

Consideration of this state of public attitude toward us brings to the fore the great problem that confronts us.

We need no new objectives. We have no objectives that should be dropped. We have a very complete program which has been gradually developed during the past few years, and is crystalized in the committee reports to be acted upon by this House of Delegates.

The program for the start of the year will not be that of your officers nor of your committees; but the action of this House of Delegates will be the program of The Medical Society of New Jersey. It is altruistic toward the public, and it promotes the best interests of our profession. It is the result of the best thought of all of us, and worthy of our best effort. Realization of the program is the main objective for the coming year. Our work is cut out for us.

Success will require close coöperation between our profession and the public. We can do nothing by ourselves. The public will do nothing without a better understanding of our motives.

First of all, then, we must enlist the active interest of a much greater number of physicians,—so far as possible, of *every member* of our Society. Due largely to the improved organization introduced by President Carrington and to his enthusiastic leadership, a much greater number have taken an active part during the present year. This number must greatly increase. Every member of each county society should know our program, so as to be able to discuss it with patients and friends, and to promote our objectives before lay organizations. A well-informed, united profession can accomplish anything. It is necessary for success.

Secondly, we must secure greater coöperation from the public. Much has been accomplished. Our Public Relations Committee has done fine work. Its program should be con-

tinued, and new avenues of public approach sought. Of all the possible avenues of approach, a well-informed, active medical profession, participating 100 per cent, would be the best. If we can secure this, we shall accomplish our objectives.

We are living at a time when radical changes seem to be impending. Adequate medical care stands next in importance to food, clothing, and shelter. It is one of the realms in which revolutionary changes have been suggested and are at present being discussed.

As with other contemplated changes, the final settlement will rest with public opinion, and in reaching their decision, the public should have for its guidance viewpoints from every possible angle.

The medical profession by training and experience is best fitted to understand and to solve the problems of medical care. We should, therefore, give to the public the aid of our expert knowledge. We should be ready at all times to enter the forum of public discussion. This would be not only for the welfare of the public but also in our own interest. We have much at stake.

Personally, I have great confidence in the spirit of freedom and of fair play which is the basis of the American system. There may be trying periods of trial and error, but ultimately I believe that will prevail which is for the best interest of both the public and of the profession, for our interest can never be antagonistic.

I wish to thank this Society for the very great honor which it has bestowed upon me. As the time has drawn nearer and nearer, I have come to realize that it is a great honor only because it is a great responsibility. There is much to be done. The task is too great for any one man alone. For a successful year it will be necessary that many take part. So I call upon all of you here, and all other members of our Society, to aid by their advice and their coöperation, without which the coming year cannot be a success.

THE ANNUAL MEETING OF 1939

Each year the Annual Meeting of The Medical Society of New Jersey has had an outstanding characteristic. Last year the attendance of members who registered their presence reached a new high in not only gross numbers, but also the percentage of those enrolled on the Official List. This year those who attended seemed to have enrolled earlier and stayed longer than last year; and it was probably true that the number of members present at the meeting at any one time was larger than ever before. The actual recorded attendance is set forth in Tables 1, 2, and 3.

Year	Number of Members	Number of Members at Annual Meeting	Per Cent Attending
1934	2757	515	19
1935	2871	462	16
1936	2840	582	21
1937	3225	696	22
1938	3335	869	26
1939	3473	813	23

TABLE 1.—REGISTRATION OF MEMBERS OVER A PERIOD
OF SIX YEARS

County	Delegates	Members	Auxiliary	Visitors
Atlantic	9	107	41	129
Bergen	15	19	10	7
Burlington	5	17	17	5
Camden	13	42	27	11
Cape May	4	5	2	8
Cumberland	3	5	..	4
Essex	60	120	40	71
Gloucester	5	12	12	1
Hudson	29	40	16	13
Hunterdon	3	1	..	2
Mercer	16	35	10	27
Middlesex	6	23	15	8
Monmouth	9	27	5	11
Morris	6	12	1	11
Ocean	3	7	9	4
Passaic	21	29	17	10
Salem	1	5	3	3
Somerset	4	17	6	13
Sussex	1	..	..	1
Union	19	50	14	15
Warren	..	5	1	2
Totals	232	578	246	356

Visitors from other States	38
Scientific exhibitors	32
Technical exhibitors	113
	183

Additional Registration:

Members	3
Visitors	8
	11

Delegates	232
Members	578
Auxiliary	246
Visitors	353
Visitors from other States	38
Scientific exhibitors	32
Technical exhibitors	113
Additional registration	11
Total registration	1606

TABLE 2.—THE 1939 REGISTRATION BY CLASSES

County	Number of Members	Number Attending	Per Cent
Atlantic	116	116	100
Bergen	201	34	17
Burlington	53	22	42
Camden	183	55	30
Cape May	26	9	33
Cumberland	55	8	15
Essex	942	180	19
Gloucester	45	17	38
Hudson	432	69	15
Hunterdon	27	4	15
Mercer	223	51	23
Middlesex	123	29	24
Monmouth	126	36	29
Morris	107	18	17
Ocean	27	10	37
Passaic	363	50	14
Salem	28	6	21
Somerset	55	21	38
Sussex	22	1	5
Union	292	69	24
Warren	27	5	19
Totals	3473	810	23

TABLE 3.—THE 1939 REGISTRATION BY COUNTY
MEDICAL SOCIETIES

Visiting delegations from other states were:

From New York—

Terry M. Townsend, M.D., President, New York City

Frederic E. Elliott, M.D., Brooklyn

From Connecticut—

James R. Miller, M.D., Treasurer, Hartford

Oliver L. Stringfield, M.D., Stamford

From Pennsylvania—

David W. Thomas, M.D., President, Lochaven

From Delaware—

George W. Vaughan, M.D., Wilmington

Clyde C. Neese, M.D., Wilmington

These delegates were received with cordiality, and were given every opportunity to observe all phases of the work of the Society.

FORM OF THE PRINTED PROGRAMS

Special attention had been given to the arrangement of the events, and to the form of the program. Experience in making up the printed programs has demonstrated that the members appreciate a form which is self-indexed, so that the events may be readily identified in both time and place.

In 1938 the official program measured $4\frac{1}{4}$ by $8\frac{3}{4}$ inches, and was folded so that it opened *from side to side*, like an ordinary book. Its distinctive features were:

1. The name of the section of the program was printed on the right edge of the first leaf of each group of subjects.

2. A half-inch strip below the label was then cut away, leaving all the labels exposed, one below another.

The notching required hand labor, and the process was therefore slow and expensive.

Committee

courtesy, and cuisine.

nan .. Newark
.. Belmar
.. Morristown
.. Trenton
.. Somerville

consider reports of:
fense and Insurance
c Relations

nan .. Newark
.. Bayonne
.. Trenton
.. Perth Amboy
.. Summit

consider reports of:
and Arrangements
titled Program
titled Exhibits
Woman's Auxiliary

in .. Morristown
.. Jersey City
.. Asbury Park
.. Bayonne
.. Lakewood

HOUSE OF
DELEGATES
SCIENTIFIC
EXHIBITS
WOMAN'S
AUXILIARY

The officers of the Society are anxious to greet each of you personally, and to shake your hand. Together we may make the 173rd Annual Meeting the most friendly and the most successful in the long and illustrious history of this Society.

WILLIAM J. CARLINGTON, President.
CHARLES B. KASHIN, Chairman of the
Committee on the Annual Meeting.

GREETINGS AND ANNOUNCEMENTS

OFFICIAL EVENTS

SCIENTIFIC PROGRAM

SPEAKERS

SCIENTIFIC EXHIBITS

HOUSE OF DELEGATES

TECHNICAL EXHIBITS

WOMAN'S AUXILIARY

SELF-INDEXED PROGRAM

Left—1938 form,—index on the right side.

Right—1939 form,—index on the bottom.

In 1939 the booklet of the program measured $3\frac{7}{8}$ by 9 inches, and opened endwise with the hinge parallel to the lines of the text. Its distinctive features were:

1. A title was printed at the bottom of the first leaf of each section.

2. The leaves of each section were made one-quarter of an inch shorter than those of the next section.

By this arrangement the titles were always in plain view even when the book was closed. The cost of this form of program was about the same as that of the 1938 form; but it can be made up quickly by any printer without outside aid.

Query to Members—Do you value the self-

index form sufficiently to approve its extra cost?

SPIRIT OF THE HOUSE OF DELEGATES

The sessions of the House of Delegates were the culmination of the work of the official year that had just closed. The administrative year began at the adjournment of the House of Delegates on May 19, 1938, and ended at its adjournment on June eighth,—a period of one year and twenty days.

In another respect the official year was longer than usual because the personnel of the several committees had been announced immediately after the close of the House of Delegates on May nineteenth; and all the committees met for organization on June fifth, and at that time each chairman outlined his program for the year's work. Then when all the committees held their next formal meetings on October second, their organized work for the year was well under way, and continued to progress with increasing activity until the final assembly of all the committees on April 16, to consider their reports and recommendations to be presented to the House of Delegates on June sixth. These reports were published in the May Journal, and were in the hands of every member over three weeks before the opening of the annual meeting. The only exceptions to this prompt publication of the reports arose from the fact that some of the most important committees had continued their activities and presented the results to the House of Delegates in the form of supplementary reports which had been mimeographed and placed in the hands of each delegate. Preparations for intelligent discussions of the annual reports were more complete than ever before.

Faced with proposed Federal legislation along revolutionary lines, the members of the House of Delegates showed an earnestness of purpose and seriousness of thought that was reflected in the variety of suggested remedies rather than in jealous competition for the adoption of any one plan. The special problem before the delegates was the development of a comprehensive medical service for the benefit of those who were financially unable to meet the costs of modern diagnostic tests and therapeutic measures. In this evolution of new plans, new laws will have to be passed and old laws legally interpreted. The members of the House of Delegates therefore acted conservatively and approved plans for making accurate diagnoses before applying radical remedies.

The Transactions of the House of Delegates will be published in the August Journal.

SCIENTIFIC MEETINGS

The scientific work of the Society was conducted in four groups of sessions, as follows:

1.

A general session on Medical Administration, with three outstanding speakers of national reputation, as follows:

Haven Emerson, M.D., Professor of Public Health Practice, College of Physicians and Surgeons, Columbia University, New York City.

Rock Sleyster, M.D., Wauwatosa, Wisconsin, President, the American Medical Association.

Nathan B. Van Etten, M.D., New York City, President-Elect, the American Medical Association.

2.

A joint meeting of The Medical Society of New Jersey with the New Jersey Hospital Association, over which Edward Guion, M.D., President of the Hospital Association, presided and whose speakers were:

G. Harvey Agnew, M.D., Toronto, Canada, President, the American Hospital Association, on "The Doctor and His Workshop".

William J. Carrington, M.D., President, The Medical Society of New Jersey, on "The Hospital and the Doctor".

With the background of these two groups of addresses, the supplementary report of the Committee on Hospital Relationships is of immediate interest; and therefore the five addresses and the committee report are printed as a group on pages 410 to 439 of this Journal.

3.

Three combined meetings of six of the seven scientific sections of the Society.

The number of speakers was thirteen.

4.

Eight sessions of the seven sections into which the scientific work of the Society is divided.

The number of speakers was forty-five.

The total number of speakers listed was sixty-one.

The guest speakers numbered twenty-five, of whom portraits of twenty were printed in the program.

There were forty-three New Jersey physicians listed as speakers or discussors on the scientific programs.

The programs and the portraits of twenty of the guest speakers were printed on pages 332-338 of the May Journal. The scientific addresses delivered before the scientific sections will be published in installments in the Journal throughout the year.

SCIENTIFIC EXHIBITS

Fifty scientific exhibits were shown in commodious booths, arranged under the direction of Dr. Asher Yaguda, of Newark, Chairman of the Sub-Committee on Scientific Exhibits for the annual meeting. These exhibits were of an unusually high standard, and attracted the well-deserved attention of throngs of visitors.

Awards were made as follows:

FOR ORIGINAL WORK OF MERITORIOUS EXCELLENCE

First: Cardiovascular Renal Disease

Drs. F. W. Konzelmann, W. I. Lillie, E. Weiss, L. W. Smith, E. S. Gault, Temple University Medical School, Philadelphia, Pa.

Second: Sphincter of Oddi: Experimental and Clinical Studies

Drs. Ralph Colp, Henry Doubilet, and I. E. Gerber, The Mount Sinai Hospital, New York City

Third: Mechanism and Control of Hemorrhage

Drs. Arthur Steinberg, W. R. Brown, E. A. Schumann, C. T. Beechman, and H. Segal, Kensington Hospital for Women, Philadelphia, Pa.

Honorable Mention: Oxygen in Blood; Clinical Application

Dr. William G. Exton, and Anton R. Rose, Ph.D., Newark, N. J.

FOR EXHIBITS OF MERITORIOUS EXCELLENCE

Open only to New Jersey exhibitors

First: Acute Respiratory Infections

Drs. L. S. Ylvisaker, H. B. Kirkland, and C. E. Kiessling, Newark, N. J.

Second: Diagnosis and Treatment of Pneumonia

Drs. Charles Rathgeber, Joseph Sorett, and S. A. Goldberg, Presbyterian Hospital, Newark, N. J.

Third: What the General Practitioner Should Know About Tuberculosis

Drs. B. S. Pollak and B. P. Potter, Hudson County Tuberculosis Hospital, Jersey City, N. J.

Honorable Mention: Juvenile Hypopituitarism and Hypogonadism

Drs. Rita Finkler, Sidney Keller, B. Rothhouse, R. Bass, E. Ward, Z. Marks, and G. M. Cohn, Beth Israel Hospital, Newark, N. J.

EXHIBIT OF ART AND MEDICAL HISTORY

The annual exhibit of Art and Medical History objects made by physicians and their wives was a most satisfactory event of the annual meeting, under the chairmanship of Mrs. Ily R. Beir, of Atlantic City, who has successfully conducted a similar exhibit for the American Medical Association for two years. The exhibit was held in a spacious room adjoining the scientific and technical exhibits, so that it was easily accessible to the members and their wives. The following table shows the attendance of the visitors who registered:

Physicians, 393, an increase of 75 per cent over the registration of last year
Ladies, 431, an increase of 90 per cent
Total registration, 824, an increase of 80 per cent

Many visitors were unable to register owing to the congestion at the registration table. It is proposed to have two registration tables next year.

While the specimens of art were unusually abundant and pleasing, the historical exhibit was especially attractive and satisfactory, for it represented the result of two years' research conducted as a project of The Medical Society of New Jersey, and the County Medical Societies. The exhibits included the following features:

Charts of the attendance of each individual member during the early days of the Society.

Photostats of the pages of the earliest minute books of the meetings of the State Society, and of some of the County Societies.

Histories of County Societies, written by their own historians.

Collections of biographies of living members of four county societies, compiled by members of the Auxiliary.

Collection of data on the development of special projects of the State Society.

A record of the scientific papers presented before the State Society during the first century of its existence.

A forty-page record of the genealogy of the Fithian family, which supplied a President and many members of the State Society up to the present time.

As a result of conversations with several physicians, a number of "Leads" to valuable records of medical history were discovered. Much of this material had lay dormant simply because there was no organized interest in medical history. But now that the medical history has become a recognized objective of The Medical Society of New Jersey, the discovery of a great mass of early medical records of New Jersey physicians may confidently be expected.

On Wednesday afternoon an address on the opportunities of the Auxiliary in popular medical education, art, and medical history was given by Dr. Frank Overton, Editor of The Journal. This address is printed on page 469 in the Woman's Auxiliary section of this Journal.

A record of the items of the exhibits shown by the Auxiliary will be published in the Transactions of the annual meeting to be issued as a supplement to the August Journal.

TECHNICAL EXHIBITS

The exhibits of commercial wares attracted more attention than ever. The exhibit space was well located in the corridors leading to the assembly rooms and scientific exhibits, and

more booths could have been sold if space for them had been available.

The rental of space for the exhibits and business details was under the management of Mr. J. B. Tufts, who is well known to all the exhibitors, and enjoys their friendly confidence. The net income from the rentals is sufficient to meet practically all the expenses of the annual meeting.

The exhibitors were generous in distributing free samples of their wares. Early on Wednesday evening the Mennen Company staged a special reception with refreshments, at which over 400 physicians and ladies were present.

THE PRESIDENT'S BANQUET

The principal social event of the annual meeting was the Reception and Banquet tendered to President and Mrs. Carrington on Wednesday evening. The call for tickets was so great that the banquet hall was completely filled, and a large group had to be accommodated in another dining room.

Dr. Hilton S. Read, of Ventnor, Chairman of the Welfare Committee, presided, and after the dinner introduced a number of guests of the Society. President Carrington presented the chairmen of the committees and other leaders of its activities with engrossed certificates in recognition of their services.

Past President Andrew F. McBride, of Paterson, presented President Carrington with the golden key of his fellowship; and Dr. Henry C. Barkhorn, Chairman of the Publication Committee, presented him with a bound volume of The Journal covering his months of service and the records of his administration.

Dr. Carrington responded with a few words of appreciation of the efficient activities and loyal support of all the officers and members during his term of office.

The exercises closed with happy words of greeting from the incoming President, Dr. E. Zeh Hawkes, of Newark.

After the banquet and speaking, the guests assembled in the large Viking Room of the hotel. A medical play, "Nuts to You", was presented by the Atlantic City Kiwanis Club Band Table, to the delight of the audience which filled the assembly room to overflowing.

The event closed with dancing in the Benjamin West Room after an evening of sociability and enjoyment.

DINNERS

A number of social dinners of special groups were held during the annual meeting, among them being:

The Fellows of The Medical Society of New Jersey

The Board of Medical Examiners and their invited guests

The Board of Trustees of The Medical Society of New Jersey

Radiological Society of New Jersey

Joint Committee on Professional Relations

The American College of Surgeons, in honor of Dr. George Mueller, President-Elect, Philadelphia, Pa.

CONCLUSION

Altogether the 173rd Annual Meeting of The Medical Society of New Jersey was the most active and the most constructive and the most harmonious annual meeting that has ever been held. This could also be truthfully said of each of the annual meetings that have been held during the past two or three years, since the improvement has been progressive. The meeting that has just closed was largely the fruitage of labors of experienced leaders who are still the inspiration of their medical colleagues.

EXHIBIT ON THE NEW JERSEY FORMULARY

The Joint Committee on Professional Relations had a creditable demonstration in the Scientific Exhibits of the Annual Meeting,



showing the preparations that are included in the New Jersey Formulary. This formulary is issued by the Joint Committee on Professional Relations, which is composed of the Committee on Pharmaceutical Problems of

The Medical Society of New Jersey, and the Committee on Professional Relations of the New Jersey Pharmaceutical Association.

There is a very noticeable and increasing degree of coöperation between the medical and pharmaceutical professions in our State. The closely woven interests of the two professions require a mutual understanding. The Joint Committee has been a helpful factor in maintaining and improving the ethical relationship between physicians and pharmacists.

The committee's chief endeavor during the past several years has been the publication and distribution of the New Jersey Formulary. Although there had been two previous editions, the present third one was the first that was distributed to every member of the society. Reports from physicians all over the State indicate that many are making good use of the book.

The Joint Committee is now giving serious study to radio advertising of patent medicines. The practice of medicine by radio is a constantly growing menace to both the laity and the medical profession. Recently, a resolution protesting against the exaggerated claims and statements made by certain proprietary manufacturers was sent to all of the leading broadcasting companies.

The officers of the Joint Committee on Professional Relations are Dr. Chester I. Ulmer, Chairman; Carl C. Christensen, Vice-Chairman; Prescott R. Loveland, Secretary; and Dr. Robert P. Fischelis, Editor.

SPECIAL HEALTH SECTION OF THE ATLANTIC CITY PRESS

On the opening day of the Annual Meeting the Atlantic City Press issued a special illustrated *Health Magazine Section* of twenty-eight pages, and distributed free copies to the visiting delegates. The section was prepared by the Atlantic County Medical Society under the direction of Dr. Samuel Barbash, Chairman of the Publication Committee. The Press pays a high compliment to President Carrington and the State Society under his leadership, and says editorially:

"This (the Health Section) will help to give to New Jersey medicine an even higher rating in the nation than it has enjoyed heretofore,—and this is saying much, for New Jersey long has commanded the highest respect of medical science, with its long list of high-class personnel, and its splendid hospital facilities."

The Health Magazine Section contains forty-four articles, as follows:

1. Welcome;—Dr. Edward F. Uzzell, President, Atlantic County Medical Society.
2. Development of The Medical Society of New Jersey; by Dr. Frank Overton, Editor of The Journal.
3. The Medical Service Plan of New Jersey; by Dr. H. L. Harley, Atlantic City.
4. Allergic Ills; by Dr. Charles Hyman, Atlantic City.
5. The Medical Society of New Jersey;—An Interpretation; by Dr. LeRoy A. Wilkes, Executive Officer, The Medical Society of New Jersey.
6. The Winning War on Tuberculosis; by Dr. Clyde M. Fish, Atlantic City.
7. The Red Cross in Emergencies; by Mrs. Warren Somers, Chairman, Atlantic City.
8. The Ambulance Service; by Dr. Samuel Barbash, Atlantic City.
9. Choose Your Doctor While You Are Well; by Dr. W. J. Carrington, Atlantic City.
10. The Country Doctor of Today; by Dr. Robert M. Grier.
11. Mosquito Control; by Fred A. Reilley, Superintendent, Atlantic County Mosquito Commission.
12. Physiotherapy in the Bacharach Home; by Dr. David B. Allman, Atlantic City.
13. The Atlantic City Hospital; by Dr. Homer I. Silvers, Atlantic City.
14. Blood Transfusions; by Dr. Robert A. Kilduffe, Ventnor.
15. The Woman's Auxiliary; by Mrs. Andrew Smith, Atlantic City.
16. Seaside Home for Invalids; by Dr. Samuel Stern, Atlantic City.
17. Internship in the Atlantic City Hospital; by Dr. J. E. Leonard, Jr.
18. The Doctor and the Pharmacist; by David Bayless, Ph.G.
19. Visiting Nurses; by Abbie G. Whidden, R.N., Atlantic City.
20. The Child Welfare Clinic; by Dr. Bernard Crane, Atlantic City.
21. Children's Seashore House; by Dr. Edward Z. Holt, Atlantic City.
22. The Bamberger Home for Poor, Invalid Children; by Mrs. S. Belle Cohen, Secretary.
23. The Weidener Memorial Summer School for Invalid Children.
24. Safe Anesthesia; by Dr. V. Earl Johnson, Atlantic City.
25. Nursing School of the Atlantic City Hospital; by Kathryn De Sales Corcoran, R.N.
26. Atlantic County Hospital for Mental Diseases; by Dr. Edw. Guion, Superintendent.
27. Conservation of Sight; by Dr. Benjamin L. Gordon, Atlantic City.
28. Cancer Research; by Dr. Harold S. Davidson, Atlantic City.
29. The Municipal Hospital; by Dr. Samuel M. Diskan.
30. The Atlantic Shores Hospital at Somers Point; by Dr. J. Rostin White.
31. Preventive Measures in Contagion; by Dr. Samuel L. Salasin, Health Officer, Atlantic City.
32. Breast Feeding of Infants; by Dr. Walter B. Stewart, Atlantic City.
33. Maternal Welfare; by Dr. A. G. Merendino, Atlantic City.
34. Prenatal Care; by Dr. Edward H. Dyer, Atlantic City.
35. Trials and Tribulations of a Physician; by Dr. D. Ward Scanlan, Atlantic City.
36. Mental Ills; by Dr. Samuel F. Gorson, Atlantic City.
37. Noise and Health; by Dr. Louis Feinstein, Atlantic City.
38. Dentistry and Medicine; by Raymond B. Ingersoll, D.D.S., Atlantic City.
39. Socialized Medicine; by Dr. Ernest L. Shore, Atlantic City.
40. Mental Ills; by Dr. W. Cole Davis, Atlantic City.
41. The School Doctor; by Dr. Norman J. Quinn, Atlantic City.
42. Better Homes and Health; by Dr. J. Hurlong Scott, Atlantic City.
43. The Prostate Gland; by Dr. Charles H. deT. Shivers, Atlantic City.
44. Venereal Disease Control; by Dr. Karl M. Scott.
45. Mercer Memorial House; by Mrs. Stella Dowdell, Superintendent.

The articles are excellent adaptations of medical subjects to the popular reader, and are models for physicians to follow in their popular medical talks. Every physician should preserve his copy of the Health Magazine Section of the Atlantic City Press, and consult it when he is invited to give a popular medical address.

Atlantic City Press

ATLANTIC CITY, N. J., TUESDAY, JUNE 6, 1939

HEALTH SECTION

*Prepared by the ATLANTIC COUNTY MEDICAL SOCIETY
and dedicated to the MEDICAL SOCIETY of NEW JERSEY*

OFFICERS of the MEDICAL SOCIETY of NEW JERSEY



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President



WATSON B. MORRIS M.D.
First Vice-President



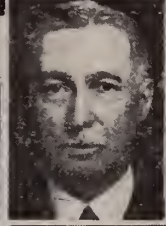
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Officers of the MEDICAL SOCIETY OF



EARL V. JOHNSON M.D.
Vice-President



EDWARD F. UZZELL M.D.
President

of the ATLANTIC COUNTY



J. CARLISLE BROWN M.D.
Secretary



DAVID B. ALLMAN M.D.
Treasurer



CHARLES HYMAN M.D.
Reporter

Welcome to the Medical Society of New Jersey

EDWARD F. UZZELL, M.D.
President, Atlantic County Medical Society

The Atlantic County Medical Society, through its 130 members, extends a cordial welcome to the visiting members of the Medical Society of New Jersey, upon the occasion of the 173rd Annual Meeting of the State Society, from June 6 to 8.

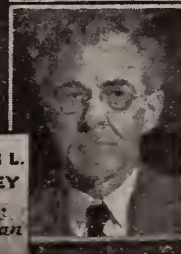
It is the sincere desire of the officers and members of the Atlantic County Medical Society that this meeting shall be a memorable one. For years, our County Society has had a most pleasant task,—that of serving as host to the State Society. We have come to look forward to this gathering with keen pleasure,—the pleasure of seeing many familiar faces and of renewing a host of former acquaintances, which adds much to the success of the Annual Meeting.

While the Scientific Assembly will occupy the principal interest, it is hoped that our guests will find opportunity to avail themselves of the many entertainment features that have been provided.

For detailed information, the Society has provided an Information desk at the Registration-Booth in Haddon Hall, the official headquarters of the meeting.



SAMUEL BARBASH M.D.
Chairman of Publication Committee & Editor of Health Section



HALVOR L. HARLEY M.D.
Historian

CHARTER OF 1807

The first fruit of the exhibit of Art and Medical History of the Woman's Auxiliary at the meeting of The Medical Society of New Jersey is a contribution by Dr. Daniel F. Remer, of Mount Holly, N. J., in the form of a printed letter, dated May 27, 1807, which had been sent to each member of The Medical Society of New Jersey. This particular letter was addressed "Doctor Stratton, Burlington", and was post-marked "New Brunswick (N. J.) May 28".

The occasion for this circular letter was mentioned in the minutes of November 3, 1795, which said:

"On motion, ordered that Drs. L. Dunham, John Beatty, William Campfield, John Wall and Elisha Newell be a committee to confer with the Medical Society formed in the eastern counties of this State, or a committee of the same on the subject of an union of the Societies; that they meet at the city of New Brunswick, at such time as shall be agreed on, and that they report their proceedings thereon to the Board at their next meeting."

The medical society to which reference is made had been formed in Newark. There seems to be little information available regarding it, but the minutes of the meeting of the State Society held on November 3, 1790, read:

"It be represented that Dr. Micheau has taken an active part in originating and establishing a Society in the County of Essex, new and independent of this corporation, and the board deeming his conduct as a member of this Society very reprehensible—Ordered, that the Secretary write to Dr. Micheau and enclose him a copy of this minute, and require his attendance at the next stated meeting to answer in the premises."

Dr. Paul Micheau was a native of Staten Island and came from a prominent family. Few details of his life are available. He seems to have received his medical education in London and advertised himself as a member of the London Medical Lyceum. His credentials were accepted and he was admitted a member of The Medical Society of New Jersey on May 5, 1789, but this was the only meeting which he attended. He advertised a two months' complete course of lectures in medicine for a charge of five pounds. He organized a society which was a rival of the State Society, but further details of his life are not available.

The second reason given for the lack of interest in the State Society was stated by

Past President Dr. Jephtha B. Munn, in an address before the Annual Meeting on May 9, 1848, in which he said (N. J. Medical Reporter, Vol. 1, Number 4, July, 1848, page 283):

"The cause of this discontinuance in holding their meetings is stated to have been by reason of the small number of their attending members becoming reduced by age, infirmity, death, removal, and otherwise, so that a quorum, according to the terms of their charter, could not be obtained to meet and organize for business; therefore a circular invitation was given by some of the members to all licensed practitioners in the State to meet with them and become members of the Society on the 23d of June, 1807, aforesaid.

"At this time and place nineteen individuals of the medical profession attended in consequence of the foregoing invitation and became members, of which the writer of this narrative was one."

Nine members of the Society and nineteen other practitioners signed Articles of Agreement as members of the Society, whose first act was to obtain an act of the Legislature, passed December 1, 1807, enlarging the scope of the society.

The doctors whose names appear on the circular were as follows:

Moses Scott, born 1738, died 1828. Was President in 1789. Was prominent as a soldier in the Revolutionary Army. Practiced in New Brunswick.

Lewis Dunham, born 1754, died 1821. Practiced in New Brunswick. Was President twice,—in 1791 and 1816. Was a Revolutionary soldier. Jacob Dunham, brother and partner of Lewis, born 1769, died 1832.

Peter I. Stryker, Somerville, born 1766, died 1859. A Revolutionary soldier. President three times—1808, 1817, and 1824.

Charles Smith, New Brunswick, born 1768, died 1848. Studied under Dr. Moses Scott. and was elected President in 1811.

Dr. Stratton, to whom the letter of invitation was addressed, was probably John L., born 1788, and died 1845. He belonged to a "Medical" family, and practiced in Burlington.

The Society was reorganized according to schedule in McGraw's Hotel, New Brunswick, which was the same hotel in which,—under the name of Mr. Duff's,—the Society had been organized in 1766.

CIRCULAR.

THE SUBSCRIBERS regretting the present neglected state of the medical society of New Jersey, and being sensible that the charter of incorporation must ere long be lost, thro' a failure of members, have thought it a duty to make an effort to rescue from oblivion and restore to its former estimation an institution so reputable to its founders and supporters, and so well calculated to be useful to the publick at large.

In order to effect this desirable object, they earnestly solicit your co-operation and attendance at Mr Degraw's Tavern, in this city, on the 4th Tuesday of June, at 11 o'clock, A. M.

It is intended to invite not only the members of the medical society, but such other gentlemen of respectable character, and standing in the profession as may be known to us; and we will thank you to extend invitations to gentlemen of the above description, in your vicinity. Should a sufficient number of the society convene to form a board, such measures may probably be taken as will in future relieve us from our present unhappy dilemma; and on this account we are more anxious that every member should duly consider how important and necessary his attendance on that occasion will be.

Should the present attempt fail, there will remain no hope of continuing an institution which in utility is inferior to none of the kind, and in point of time the oldest in the United States, the only alternative left us, will be to give it up altogether, or endeavour to devise some plan which may be more likely to succeed in future.

New-Brunswick, May 27, 1807.

We are Sir,

Respectfully yours, &c.

MOSES SCOTT,
LEWIS DUNHAM, } *Members of the*
JACOB DUNHAM, } *Medical Society.*
PETER STRYKER,
CHARLES SMITH.



Sir,

We hope the purport of the above letter, which has been sent to the respective members of the medical society of New-Jersey, will meet your approbation; and we invite you to attend at the time and place above mentioned, if you have a wish to become a member of the said society, or are willing to deliberate on measures for instituting a medical society on other grounds, should it appear necessary and adviseable so to do.

Yours, &c.

MOSES SCOTT,
LEWIS DUNHAM,
JACOB DUNHAM,
PETER STRYKER,
CHARLES SMITH.

PUBLICITY OF THE 1939 ANNUAL CONVENTION OF THE MEDICAL SOCIETY OF NEW JERSEY

By JOSEPH H. KLER, M.D., New Brunswick, N. J.
Chairman Committee on Public Relations

At least 261 separate news stories dealing with the 1939 annual convention of The Medical Society of New Jersey appeared in 103 different newspapers. This was the number of clippings returned by the press clipping bureau. Of the 103 newspapers, 94 are published in New Jersey. The press of every county in the State carried stories on the convention.

Newspapers publishing stories on the convention may be classified as follows:

New Jersey daily papers	30
New Jersey weekly and semi-weekly papers	62
New Jersey Sunday papers (Newark Sunday Call)	2
	—
	94
New York City newspapers	7
Philadelphia newspapers	2
	—
	103

The stories published by the press may be grouped as follows:

Number published by New Jersey daily papers	166
Number published by New Jersey weekly and semi-weeklies	73
Number published by New Jersey Sunday papers	5
	—
	244
Number of stories published by New York City papers	13
Number of stories published by Philadelphia papers	4
	—
	261

Eleven editorials were published concerning activities of the Society at its convention, all of them favorable to the Society. Two of them were reprinted in other papers.

The Newark Evening News, represented at the convention by Mr. Thomas W. Miles, published 21 separate stories on the convention, the largest number of separate stories published by any single newspaper.

An even greater amount of space, however, was accorded to the activities of the Society by the Atlantic City Press and Union, two papers published by the same company. While the total number of separate items carried by these two papers numbered 19, the number of lines accorded to them was generous. In addition,

the Press-Union published a special medical supplement, the material for which was prepared by members of the Atlantic County Medical Society.

The amount of news matter pertaining to the convention carried by the wires of the Associated Press was large and accounted in considerable part for the generous publicity which the Society received. The Associated Press was very competently represented by Mr. W. F. Carter, of Atlantic City.

The press of the state as a whole was generous and coöperative in its efforts to inform its readers of the organizational and administrative activities of the Society, as well as in its presentation of scientific findings presented to the scientific sections by medical speakers.

Three stories for general release, spread over three weeks, were sent to the press by the Committee on Public Relations. Copies of the annual reports of the Society's committees, together with convention programs, were sent to the daily and Sunday papers. These were also sent to papers in communities in which a committee chairman resided, the local press usually showing an interest in reports written by local physicians.

Abstracts of talks delivered by physicians were also sent to each physician's home-town papers.

Special stories on the participation of Philadelphia and New York physicians in convention activities were sent respectively to Philadelphia and New York City newspapers.

The addresses of Drs. Haven Emerson and Nathan Van Etten were broadcast by Station WPG, Atlantic City.

The newspaper publicity of the 1939 annual convention appears to have been at least 80 per cent better than that of the 1938 convention. One hundred forty-two clippings were returned on the 1938 convention, compared with 261 this year. The number of weekly papers carrying stories on the 1939 convention was more than three times as great as the number which published stories in 1938. Twenty weekly papers published convention stories in 1938, compared with 62 this year. Twenty-nine daily papers carried stories last year, compared with 30 in 1939, an increase of one. This increase may possibly reflect a greater recognition of the Medical Society on the part of small, community newspapers to an extent greater than has been accorded to it in the past.

CHIROPRACTIC BILL

The Chiropractic Bill, S-205, passed the Senate of the New Jersey Legislature on June 26th, 1939. This Bill allows for the creation of a Board of Chiropractic Examiners, independent of the State Board of Medical Examiners.

The Bill received eleven favorable votes from the following members of the Senate:

Clifford R. Powell, Burlington County
I. Grant Scott, Cape May County
George H. Stanger, Cumberland County
Robert C. Hendrickson, Gloucester County
Edward P. Stout, Hudson County
Arthur F. Foran, Hunterdon County
John E. Toolan, Middlesex County
James K. Allardice, Ocean County
Charles E. Loizeaux, Union County
Haydn Proctor, Monmouth County
Crawford Jamieson, Mercer County

If this bill is enacted into law, this Board of Examiners will independently license practitioners to practice under the following definition of chiropractic contained in the Bill:

"Chiropractic" is hereby defined to be the science, art, and philosophy of things natural; a system of

adjusting the vertebral column and of the tissues adjacent thereto by hand for the removal of nerve interference thereby to eliminate the cause of disease.

This definition is an attempt to simplify that of the law of 1920, which reads:

The term chiropractic when used in this act shall be construed to mean and be the name given to the study and application of a universal philosophy of biology, theology, theosophy, health, disease, death, the science of the cause of disease and art of permitting the restoration of the triune relationships between all attributes necessary to normal composite forms to harmonious quantities and qualities by placing in juxtaposition the abnormal concrete positions of definite mechanical portions with each other by hand, thus correcting all subluxations of the articulations of the spinal column, for the purpose of permitting the recreation of all normal cyclic currents through nerves that were formerly not permitted to be transmitted, through impingement, but have not assumed their normal size and capacity for conduction as they emanate through intervertebral foramina—the expressions of which were formerly excessive or partially lacking—named disease.

OBITUARIES

DR. WILLIAM L. WILBUR

Dr. William L. Wilbur, aged seventy-four, President of the New Jersey State Board of Medical Examiners, died on June 11 in the Pennsylvania Hospital, Philadelphia. He had suffered from anemia, for which he had received transfusions.

Dr. Wilbur was born in Hightstown, and had lived there all his life. He graduated from the Medical Department of the University of Pennsylvania in 1885, and then was associated with his father, Dr. Lloyd Wilbur, in the practice of medicine in Hightstown until the death of the elder doctor many years ago.

Dr. Wilbur was elected to the Assembly in 1894 and 1895, and was sheriff of Mercer County in 1905. He was active in civic affairs and in the Masonic and other fraternities. He was elected a member of the New Jersey State Board of Medical Examiners on December 29, 1937; and was chosen president of the board on July 20, 1938. He was active in the Mercer County Medical Society, and The Medical Society of New Jersey.

DR. JACKSON B. PELLETT

Dr. Jackson B. Pellett, an honorary member of The Medical Society of New Jersey, died in his home in Hamburg, Sussex County, on May 3, 1939. He was born in Pellettown, Sussex County, on

August 4, 1847, and he therefore lacked only two months of being ninety-two years of age. He began his medical studies in the office of Dr. John Allen, of Lafayette, a few miles south of his home. He graduated in medicine from the College of Physicians and Surgeons in 1869, and served for two years as an interne in the Yorkville Dispensary, New York.

In 1870 Dr. Pellett began to practice in Hamburg. He specialized in eye and ear conditions, and often visited the New York Eye and Ear Infirmary for study and observation of cases. But he also did a family practice in general surgery and obstetrics.

Dr. Thomas W. Harvey, in the report of the Committee on Honorary Memberships to the House of Delegates on June 7, 1933, gave the following citation:

"Dr. Pellett is an ophthalmologist who has lived in the northern part of the State all his life and has practiced in Hamburg. I heard Dr. Kipp, of Newark, said that he had an international reputation."

Dr. Pellett leaves four sons, of whom two are physicians,—Dr. R. L. Pellett, of Franklin, and Dr. Thomas L. Pellett, of Hamburg. His wife, whom he married in 1880, is still living.

Dr. Pellett was active in the Sussex County Medical Society, and in the State Society and the A. M. A.

He was descended from Governor William Bradford of Massachusetts, and was an active member of the Mayflower Society.

DR. LETTIE ALLEN WARD

Dr. Lettie Allen Ward, aged eighty, of Camden, died in the Cooper Hospital, Camden, from pneumonia, on March 18, 1939.

Dr. Ward had retired from active practice only

a few months before her death. She was a native of the city of Camden, and served as a teacher and principal in the public schools. She graduated from the Woman's Medical College, Philadelphia, in 1898, and specialized in nose and throat work. She was an active member of the Camden County Medical Society, and the first President of the Camden Business and Professional Women's Club, and an active member of the First Baptist Church.

DECEASED PHYSICIANS OF NEW JERSEY

Data Supplied by the Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Boyd E. Wilkinson	59	Apr. 11, 1939	Paterson	Same	Arterio sclerosis.
Anthony Lisena	29	Apr. 29, 1939	Jersey City	Brooklyn	Acute endocarditis.
Sherrill G. Corpening	40	Apr. 2, 1939	Camden	Pensauken	Lobar pneumonia.
Herbert B. Vail	71	Apr. 10, 1939	Newark	Belleville	Coronary occlusion.
I. Warner Knight	56	Apr. 10, 1939	Pitman	Same	Coronary embolism.
William Barrett	90	Apr. 28, 1939	Springfield	Elizabeth	Arterio sclerosis.

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Newton H. Barnart	71	May 30, 1939	Penns Grove	Same	Suicide.
Charles L. Ill	74	May 4, 1939	Newark	Same	Coronary thrombosis.
Jackson B. Pellett	91	May 3, 1939	Hamburg	Same	Old age.
Edward B. Rogers	62	May 11, 1939	Camden	Collingswood	Pneumonia.
George H. Ward	59	May 30, 1939	Blairstown	Same	Coronary thrombosis.
James T. Wyckoff	67	May 6, 1939	Englewood	Leonia	Carcinoma of prostate.

NUMBER OF CHILDREN REPORTED AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1938

DIPHTHERIA TOXOID					SMALLPOX VACCINE				
County	Total to April 30	Month of May	Total to May 31	Average per Month	County	Total to April 30	Month of May	Total to May 31	Average per Month
Atlantic	760	17	777	70.6	Atlantic	539	11	550	50.0
Bergen	2758	984	3742	340.1	Bergen	1986	717	2703	245.7
Burlington	478	259	737	67.	Burlington	260	53	313	28.4
Camden	1400	4438	5838	530.7	Camden	2244	59	2303	209.3
Cape May	375	0	375	34.1	Cape May	347	38	385	35.
Cumberland	194	131	325	29.5	Cumberland	223	14	237	21.5
Essex	9840	866	10706	973.2	Essex	4165	348	4513	410.2
Gloucester	568	171	739	67.1	Gloucester	433	8	441	40.1
Hudson	4256	537	4793	435.7	Hudson	2960	214	3174	288.5
Hunterdon	285	253	538	48.9	Hunterdon	18	4	22	2.
Mercer	2537	47	2584	234.9	Mercer	1038	95	1133	103.
Middlesex	999	52	1051	95.5	Middlesex	1748	42	1790	162.7
Monmouth	324	16	340	30.9	Monmouth	1078	14	1092	99.2
Morris	563	84	647	58.8	Morris	828	21	849	77.1
Ocean	202	28	230	20.9	Ocean	50	52	102	9.2
Passaic	2561	344	2905	264.1	Passaic	1670	289	1959	178.1
Salem	291	36	327	29.7	Salem	402	9	411	37.3
Somerset	141	31	172	15.6	Somerset	1172	21	1193	108.4
Sussex	5	0	5	.4	Sussex	0	2	2	.1
Union	1385	1475	2860	260.	Union	1121	156	1277	116.1
Warren	431	44	475	43.1	Warren	195	27	222	20.1
Totals	30353	9813	40166	3651.4	Totals	22477	2194	24671	2242.8

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

JULY, 1939

18 Warren (Annual Meeting)

25 Hunterdon

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held at the Hotel Ambassador in Atlantic City at 9 p.m., May 12, 1939, with the President, Dr. James H. Mason, 3rd, presiding. In the absence of the Secretary, Dr. R. A. Kilduffe served as secretary pro tem.

One application for membership was received.

This being the annual meeting, there was no scientific program. Final reports for the year's activities were made by all the committee chairmen.

LEGISLATION

Special consideration was given Dr. Allman's report for the Legislative Committee, in particular reference to A-210. Letters, telegrams and personal contact with our legislators were discussed, and arrangements were made for each member to participate in this activity.

SPECIAL NEWSPAPER PUBLICITY

Dr. Barbash reported the progress of the work on the special magazine section of the *Atlantic City Press* to be published during the State convention. This will contain articles for the public on pertinent health problems, and will be prepared by members of the society.

TELEPHONE LISTINGS

A committee was appointed to interview the Bell Telephone Company in an attempt to improve the listings in the classified section so that only regular M.D.'s would appear as distinct from other types of practice.

REPORT OF FIELD PHYSICIAN

Dr. Shore, Field Physician, reported on some of the difficulties encountered in his work. He also presented some interesting charts on socialized medicine as it exists in some foreign countries.

ELECTION OF OFFICERS

The following officers were elected:

President, Dr. Edward F. Uzzell
Vice-President, Dr. V. Earl Johnson
Secretary, Dr. J. Carlisle Brown
Treasurer, Dr. David B. Allman
Reporter, Dr. Charles Hyman
Historian, Dr. Halvor L. Harley

Delegates to the State Society:

Dr. James H. Mason, 3rd Dr. H. S. Davidson
Dr. Harry Subin

Alternates:

Dr. W. P. Chalfont, Jr. Dr. R. R. White
Dr. Ernest L. Shore

State Society Nominating Committee:

Dr. D. W. Scanlon Dr. D. B. Allman

To the Board of Censors: Dr. James H. Mason, 3rd

To the Executive Committee: Dr. Robert M. Grier

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held on May 9, 1939.

The society was invited to attend the annual meeting of the Passaic County Medical Society. Other communications of interest were an invitation to attend a Public Health Service Night in Tenafly, and a letter from a Maryland physician giving a description of instruments stolen from him which might be offered for sale.

MEDICAL SURVEY

The findings and conclusions of the report from the Executive Offices in Trenton, outlining the result of the A. M. A. Survey in Bergen County, were read to the society.

The following members of the society were unanimously elected to office:

President, G. Milton Knowles, of Hackensack
Vice-President, Russell K. Tether, of Closter
Secretary, G. Barton Barlow, of Englewood
Treasurer, William K. Harryman, of Hackensack

Reporter, A. T. V. Brennan, of Englewood

These men will assume their offices at the next regular meeting, which will be the first after the State convention.

BOY SCOUTS

Dr. Essertier, of Hackensack, spoke concerning the physical examination of Boy Scouts applying for admission to the Boy Scout camps, and informed the members what the Boy Scout Council desired particularly in these examinations.

WOMAN'S AUXILIARY

Mrs. Walter Farr, President of the Woman's Auxiliary was introduced and made an earnest plea for increased interest and membership in the Auxiliary.

SCIENTIFIC

The Scientific Committee introduced as the speaker of the evening Dr. Paul Wood, Secretary of the American Association of Anesthetists. He gave an interesting account of the development of anesthesia in all its forms, and discussed at length the newer anesthetic agents.

BURLINGTON COUNTY

Paul R. Sparks, M.D., Reporter

The annual meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club May 11, 1939. Retiring President Fahrenbruch presented the annual report.

ELECTION OF OFFICERS

The following officers were elected for the coming year:

President, Charles Munro
Vice-President, George Tracey
Secretary, Warren Rodman
Treasurer, E. Vernon Davis
Reporter, Paul R. Sparks

Following his induction to the chair, President-Elect Munro announced his objectives for the year, and his committee appointments.

TIME OF ANNUAL MEETING

The matter of holding the annual meeting in the spring and the annual election in fall, with incumbents to assume office the following spring, in order that our year might coincide with that of the State Society's, was adopted.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The annual meeting of the *Camden County Medical Society* was held May 2, 1939, at 9 p.m., at the City Dispensary Building, with President H. Wesley Jack presiding.

MOVIES OF 1929

Movies of the annual outing in 1929 were shown and were received with deep interest.

NEW OFFICERS

The following officers were elected:

President, I. E. Deibert
President-Elect, Robert S. Gamon
Secretary, George B. German
Reporter, Harold D. Barnshaw
Treasurer, E. C. Shull
Historian, H. B. Decker
Trustee, Joseph E. Roberts, Jr.
Censor, H. Wesley Jack

The Treasurer's report was read by the Secretary, and was accepted.

MEMORIAL TO DR. LETTIE ALLEN WARD

A memorial was adopted to Dr. Lettie Allen Ward, an esteemed member of the society, who died on March 18. (See obituary, p. 462.)

HISTORICAL

Dr. H. B. Decker, Historian, presented a brief résumé of the early meetings of the society. It was moved that the report be accepted with thanks of the society.

INSTALLATION OF OFFICERS

Dr. H. Wesley Jack, retiring President, presented the annual address.

The oath of office was read to the recently elected officers, and Dr. Deibert, the President, outlined his objectives for the coming year.

CAPE MAY COUNTY

Warren D. Robbins, M.D., Reporter

The spring meeting of the *Cape May County Medical Society* was held on May 16, 1939, at Simms Restaurant, Ocean City, N. J.

DATE OF ANNUAL MEETING

The following resolution was offered by Dr. Corson, seconded by Dr. F. Hughes, and adopted: "The election of officers of this society shall be held during the month of April." This changes the annual meeting from October to April.

ELECTION

The following officers were unanimously elected:

President, Dr. A. C. Crowe, Ocean City
Vice-President, Dr. Samuel Hughes, Wildwood
Secretary and Reporter, Dr. C. W. Way, Sea Isle City

Treasurer, Dr. Warren D. Robbins, Cape May

The society voted unanimously that the newly elected Treasurer accept from the estate of Dr. H. H. Tomlin a check for \$235.83 as representing in full the amount of funds in the treasury at the time of our past Treasurer's death.

A letter from the widow of our deceased President, the late Dr. H. H. Tomlin, was read.

CUMBERLAND COUNTY

F. M. Ramsey, M.D., Reporter

Every other month a meeting of the *Cumberland County Medical Society* is held in the evening at 9 p.m. with members from the society presenting papers. May 8, 1939, the meeting was held in Newcomb Hospital, Vineland, N. J.

BUSINESS

The Chairman of the Committee on the Formation of a Ladies' Auxiliary reported that, among the consulted, twenty-seven were in favor of an auxiliary, while thirty-six were opposed. The matter was left to the committee for further consideration.

SCIENTIFIC

Dr. Edward Thalheimer, of the Vineland Hospital staff, presented the subject "Childhood Tuberculosis". The paper proved most interesting, especially since a number of cases were discussed, and x-rays shown from the chest clinic of the Children's Hospital in which Dr. Thalheimer works. The main point that was stressed was the fact that contact cases are not thoroughly investigated. Each home

where a tuberculous patient is diagnosed should have each member of the household tuberculin-tested, and any positive case further studied. Dr. Thalheimer further pointed out the importance of segregating the infected cases. Primary tuberculosis in a child is more common than supposed.

Although extensive work is being done in the high schools along the lines of tuberculosis investigation, it is felt that this study should be started at an earlier age. The primary cases are too readily overlooked.

The *Cumberland County Medical Society* held its regular afternoon meeting on June 13, at 2:30 p. m. at Ivy Manor, Jericho, N. J., with President J. Franklin Reeves presiding.

NEW MEMBERS

Dr. Leon J. Schwartz, 42 Broad Street, Bridgeton, was elected to membership.

Drs. Millard Sewall and Garrett Miller spoke briefly on a drive for new members. They are of the opinion that more new members should be admitted to the society.

STATE SOCIETY MEETING

Dr. Chester I. Ulmer, Gibbstown, Councilor of the Fifth Judicial District, gave a brief report on the Annual Meeting of The Medical Society of New Jersey at Atlantic City. He was most enthusiastic in his praise of President Dr. William J. Carrington.

SCIENTIFIC

Dr. Hines, from the Cancer Clinic of the Homeopathic Hospital, Wilmington, Delaware, spoke on the "Diagnosis and Treatment of Cancer". He emphasized the prevalence of cancer, the basic means of diagnosis, and the importance of attention to suggestive symptoms, such as bleeding.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The annual meeting of the *Essex County Medical Society* was held at the Academy of Medicine on Thursday, May 11th, 1939, at 9 p. m., with President David Kraker presiding.

COMMITTEE REPORTS

Reports of the several committees were read, and their publication in the Bulletin of the society was ordered.

The *Economics Committee*, under the leadership of Dr. Comando, has been hard at work solving the medical problems on economy for the members.

Dr. Stuart Hawkes reported on *Post-Graduate Instruction*. He said that in the various hospitals there has been much groundwork in this direction. The committee has done lots of thinking and has been on the lookout for post-graduate work of much value in this section.

Dr. H. C. Barkhorn reported for the *Committee on Publication*. The Bulletin has developed from a mere four-page pamphlet to a regular-sized Bulletin.

Dr. Charles Robbins, under *Public Health*, spoke of the success of the work done in Pneumonia Control.

Dr. Royal Schaaf said the aim of the *Public Relations Committee* was better relations between the laity and the medical profession. No person should be denied medical care on account of lack of funds. He spoke of the list of specialists who had volunteered their services to the needy. The Speakers' Bureau had forty-five speakers who made eighty-six addresses.

Dr. Crecca, for the *Credentials Committee*, reported that it had approved 105 names for membership during the past year.

The *Child Welfare Committee*, Dr. Chester Brown, Chairman, reported that it was working hard on a plan where mother's milk would be on hand when it is needed. The Babies' Hospital-Coit Memorial would be a station.

Dr. Frank Bien reported for the *Welfare Committee* as to its work on legislation, and advised us to be more awake to what is going on in the Legislature, and be better politicians.

PRESIDENT'S EX-AUGURAL ADDRESS

Dr. Kraker, the retiring President, gave a résumé of the work done during his administration. He said the Life Insurance Program nearly went through, and except for a shortage of about sixty more names the policy would have been issued. The necessary amount needed was 75 per cent of the membership.

In closing, President Kraker said:

"It is more and more evident that the objective of this Society must be to continue its real coöperation, as a group, with other groups in public affairs. Limitation of this principle has made it possible to place medicine as a whole upon the defensive when even its worst enemies are willing to agree that the standard of health generally, and the status of medical practice are at their highest in the United States."

INSTALLATION OF OFFICERS

Dr. Royal A. Schaaf was installed as the new President of the society. His inaugural remarks will be printed in the Bulletin of the society.

President-Elect, Harry N. Comando, Newark

First Vice-President, Francis C. Weber, Newark

Second Vice-President, William Wheeler Cox, Montclair

Secretary, Marcus T. Greifinger, Newark

Treasurer, Robert H. Rogers, Newark

Reporter, Paul Hosp, Newark

PRESENTATIONS

Gold keys bearing the emblem of the society were presented to the living Past Presidents by Dr. William J. Carrington, President of The Medical Society of New Jersey. Those receiving keys were:

G. A. Van Wagenen, 1893	R. N. Connolly, 1928
E. J. Ill, 1896	A. W. Bingham, 1929
W. P. Eagleton, 1908	H. C. Barkhorn, 1930
H. J. Wallhauser, 1911	J. H. Lowrey, 1931
E. Z. Hawkes, 1913	W. H. Areson, 1932
H. S. Martland, 1920	E. W. Sprague, 1933

F. R. Haussling, 1921	J. F. Condon, 1934
A. J. Mitchell, 1922	A. C. Zehnder, 1935
C. R. O'Crowley, 1924	E. A. Ill, 1936
E. G. Wherry, 1925	R. R. Van Ness, 1937
Max Danzis, 1927	D. A. Kraker, 1938

NEW MEMBERS

The following physicians were elected to membership:

Active:

Paul E. Carlisle, Newark
Lindsay E. Robinson, Newark

Associate:

Walter H. Hagen, Orange
F. M. Offenkrantz, Newark

Reinstated:

Simeon Daron, Newark
Adolph Wegrocki, Newark

DR. ELMER G. WHERRY

On May 10th, the members of the Staff of the Babies' Hospital-Coit Memorial, and friends, gave a testimonial dinner to Dr. Elmer G. Wherry, Medical Director of the hospital, at the Essex House. Eighty persons were present.

Dr. Oscar Mockridge was toastmaster. Speakers were Drs. Sprague, E. Z. Hawkes, Wells P. Eagleton, Christopher C. Beling, Edward J. Ill, Mr. Frederick Wherry, Mrs. Barker, and Mr. Kitchell.

Dr. N. Antonius was chairman of the committee and was assisted by Drs. Jennings, Minard, Valentine, and Hosp. Dr. Wherry was presented with a cigarette case upon which was engraved a suitable remembrance of the occasion.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Dr. Herman W. Wright, of Pitman, was elected President of the *Gloucester County Medical Society* at the annual meeting held at the Homestead, Woodbury. He succeeds Dr. William E. Crain, of Woodbury.

Other officers elected are:

Vice-President, Henry B. Diverty, Woodbury
Secretary, Chester I. Ulmer, Gibbstown
Treasurer, Don B. Weems, Wenonah
Reporter, H. B. Diverty, Woodbury
Historian, Dorothy Rogers, Woodbury
Trustee for three years, William Brewer, Woodbury
Censor for three years, Ralph L. Moore, Woodbury
Delegate to State Medical Society for three years, W. J. Burkett; alternate, L. K. Collins
Member of Nominating Committee of State Society, B. A. Livengood; alternate, W. J. Burkett
Delegates to Burlington County: H. B. Diverty, William E. Crain, Oran A. Wood
Delegates to Camden County: Don B. Weems, I. N. Patterson, H. B. Diverty
Delegates to Cape May County: J. H. Underwood, F. G. Wandall, H. B. Diverty
Delegates to Cumberland County: W. J. Burkett, Louis K. Collins, William Brewer
Delegates to Salem County: Harry Nelson, William G. Harris, R. C. Venturo

MEMORIALS

The Committee on Resolutions, of which Dr. W. J. Burkett was Chairman, presented suitable resolutions to the society on the passing of Drs. Lumis, Downs, and Knight.

SCIENTIFIC

The scientific part of the program consisted in the presentation of interesting case reports by Dr. Collins, of Glassboro; Dr. Patterson, of Westville; and Drs. Pedrick and Venturo, of Glassboro.

Twenty-four members, and five visitors were present.

MIDDLESEX COUNTY

Howard Dieker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Middlesex General Hospital, New Brunswick, N. J., on Wednesday evening, May 24, 1939. The President, Dr. N. N. Forney, called the meeting to order at 9:20 p. m.

SCIENTIFIC PROGRAM

Dr. H. H. Ritter, Clinical Professor of Surgery at Columbia University, gave a most interesting extemporaneous talk on "The Infection Problem in Trauma". After his talk Dr. Ritter answered many questions. A free discussion of his talk also followed.

NEW MEMBERS

Dr. N. O. Bowman was elected to full membership.

NEW BUSINESS

Dr. F. M. Hoffman was elected an alternate to the State Society in place of Dr. Rowland, who is a delegate and by error also an alternate.

The meeting was adjourned at 11 p. m., after which refreshments were served by the hospital.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular meeting of the *Morris County Medical Society* was held the evening of Thursday, May 18th, at the New Jersey State Hospital at Greystone Park.

The meeting was opened by President Thomas S. Thomas; and as the program was being put on by the medical staff of the Greystone Park Hospital, the meeting was turned over to the hospital's Clinical Director, Dr. Arthur G. Lane.

SCIENTIFIC

A very interesting program was presented before a goodly attendance, a summary of which follows: "Psycho-Somatic Considerations" was presented by Dr. Malcolm C. Taylor, who discussed particularly gastric tensions and their interpretations. The subject was demonstrated by the presentation of two patients.

"The Involuntional Psychosis and Estrogenic Treatment" was the topic of Dr. Wilbur M. Judd, who demonstrated that massive doses were necessary to obtain improvement, particularly in cases of melancholia.

"Atropine in the Treatment of Post-Encephalitis" was the subject presented by Dr. Robert Lamb. The superiority of this drug was demonstrated in several cases.

"Insulin Shock" was the subject presented by Dr. Phyllis D. Schaefer. The speaker traced the progress of patients whose treatment had been reported to the society a year ago.

"Post-Operative Mental Changes Following Thyroidectomy" was presented by Dr. Edward Kessler. He showed that the psychoses definitely due to endocrine imbalance were improved by the operation; but the patients whose psychoses antedated the thyroid trouble were not helped mentally by the operation.

After the scientific session, refreshments and a social period were enjoyed in the hospital cafeteria.

OCEAN COUNTY

L. Robert Carmona, M.D., Reporter

The regular annual meeting of the *Ocean County Medical Society* was held at Eno's Hotel in Forked River on the evening of May 10, 1939. President Emanuel Sickel presided. Those present were Drs. Bierach, Bloomberg, Buermann, Bunnell, Carmona, Dodd, Goldstein, Green, Halbach, Hayden, Heberner, Hendricksen, Hogan, McIlvaine, Menge, Obert, Schneider, Sickel, Szold, Thompson, Towbin, and Witte.

ELECTION

Dr. Towbin, Chairman of the Nominating Committee, brought in the recommendations, and the following officers were unanimously elected for the ensuing year:

President, J. Edwin Obert, New Egypt
Vice-President, William E. Dodd, Beach Haven
Secretary, Harry S. Ivory, Point Pleasant
Treasurer, Carl Menge, Toms River
Reporter, L. Robert Carmona, Tuckerton
Delegates to the State Society:
Adolph Towbin, Nominating Delegate, Lakewood
Theodore Thompson, Lakewood
L. Robert Carmona, Tuckerton
Alternate Delegates to State Society:
Frederick Bunnell, Barnegat
Blackwell Sawyer, Toms River
A. Goldstein, Lakewood

Dr. Emanuel Sickel, the retiring President, gave his farewell address, and the chair was turned over to Dr. Obert, the incoming President.

LEGISLATION

The Secretary was instructed to draw up a proper resolution and send it to our Senator, urging his support of Bill A-210 (Uniform Medical Practice Act) and his opposition to Bill S-205.

Dr. Halbach introduced a resolution that the Ocean County Medical Society go on record as sup-

porting Senator Reynolds' Bill. After considerable discussion the resolution was referred to the Medical Practice Committee.

SCIENTIFIC

Dr. Crossman, of Red Bank, gave a very interesting talk on *Medical Economics*, in which he showed how certain communities are paying doctors for doing indigent work. Freeport in Illinois, and Canandaigua and Olean in New York were cited as examples. Dr. Crossman also gave a demonstration of certain aspects of electro-surgery by means of high-frequency apparatus, and showed photographs of several of his cases treated by electro-coagulation.

The meeting was adjourned at 11:30 p.m.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The ninety-sixth annual meeting of the *Passaic County Medical Society* was held at the Eastside Presbyterian Church, Paterson, Thursday evening, May 11, 1939. The President, Dr. L. G. Shapiro, presided.

The committee reports as printed in the Bulletin were adopted as a whole.

MEMORIAL

The society passed resolutions in memory of Dr. Boyd E. Wilkinson, who died on February 24, 1939, and whose obituary was printed on page 388 of the June Journal.

NEW MEMBERS

The following new members were elected:

To active membership—

David Doktor, Paterson
Hyman Jaffe, Passaic
Herbert I. Katz, Paterson
Otto Schaefer, Paterson
Morris Stern, Clifton
James J. Vanderbeck, Paterson

To associate membership:

Gerald M. Feigen, Paterson
Dora Joelson, Paterson
Irving H. Saxe, Passaic
Ezra Schlossberg, Passaic
Louis Small, Passaic
M. Edward Tell, Passaic

ELECTION

The following officers were elected:

President, Wayne W. Hall
First Vice-President, Francis W. Ash
Second Vice-President, Sigurd Johnsen
Secretary, J. Allen Yager
Treasurer, Harry Wolfson
Reporter, Irving Okin

Member of Board of Censors (three years): Louis G. Shapiro

The annual dues were fixed at \$25.00, the same as last year.

HOSPITAL SERVICE

Dr. J. Allen Yager announced that a poll was being taken of the members of the county medical society; and if at least 30 per cent were agreeable, the hospital service would be available to the members as a group.

SCIENTIFIC

The scientific session was on the subject "Comprehensive Planning of Medical Care".

"The Role of the Hospital and Welfare Agency" was presented by Dr. Joseph H. Kler, Chairman of the Executive Committee of the New Jersey Health and Welfare Conference called by Governor Moore. Dr. Kler explained the organization of the conference and the sub-committees on the divisions of the general subject.

"The Approach of the Federal Government" was the subject of an address by Dr. Haven Emerson, Professor of Public Health Practice of the College of Physicians and Surgeons, Columbia University, New York City. Dr. Emerson outlined the health functions now administered by the Federal Government, and analyzed the proposals of the Wagner Bill, showing the fallacy of many of the assumptions on which the bill is based.

TRI-COUNTY MEDICAL ASSOCIATION

The *Tri-County Medical Association* (Sussex, Warren, Morris) convened in semi-annual session on May 17, at the Shannon Lodge in Bernardsville. About thirty-five members and guests were present to enjoy an informal social hour beginning at 11:30 in the morning and followed by a delicious lunch.

The post-prandial session was turned over to Dr. Toufick Nicola of Mountainside Hospital, Montclair, N. J., who spoke on "Orthopedic Problems of Interest to the General Practitioner".

Tentative plans were laid for an outing meeting of the Association in the early Fall, probably at Phillipsburg.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

The May meeting of the *Union County Medical Society* was held at the Elizabeth General Hospital on the tenth of the month, the President, Dr. Roland Blythe, presiding.

CENTRAL MEDICAL SOCIETY OFFICE

Dr. Walsh spent some time discussing the future plans of the Medical Service Bureau, and it was decided to establish a central office for the Medical Society, in combination with the Medical Service Bureau, in the Martin Building, 1136 Jersey Street, Elizabeth, N. J. The rental of this will be paid for by the Medical Society. It will give us the necessary space for executive offices, for preparation of mimeographic work and the County Bulletin, and offices for committee meetings, bringing together in one place all the activities of the society.

Dr. K. Faulkner-Slater, who is the Executive Secretary of the County Society, was appointed Secretary-Treasurer of the Medical Service Bureau. At her request she will be bonded to cover this activity, particularly as the society does not feel it can afford the expense of an audit at this time.

The Union County Trust Company presented a plan to the directors of the bureau whereby accounts of \$50.00 or more would be collected by them on a personal loan arrangement. The rate of interest would be 6 per cent instead of the 10 per cent ordinarily charged through the Service Bureau. This would undoubtedly diminish the number of new accounts opened through the bureau. Also, the doctor would be paid for his services immediately, instead of receiving the money in installments.

LEGISLATION

Dr. Watson B. Morris, of Springfield, gave an interesting talk concerning legislation in Trenton. He also requested that each member make an effort to delay passage of the national Wagner bill until the reports concerning the need for more medical assistance in various states be completed.

SCIENTIFIC

Dr. Meredith Campbell, Professor of Urology at New York University College of Medicine, gave a most illuminating review of the common urological infections in children. He went quite extensively into developmental anomalies which resulted in urinary infections, and described the efficacy of many drugs used to combat these disorders.

Dr. Irving Lerman and Dr. James H. Maroney discussed Dr. Campbell's presentation.

NEW MEMBER

Dr. T. R. Cox, 115 Princeton Road, Elizabeth, N. J., was unanimously elected to membership.

A dinner was given to Dr. Charles Henry Schlichter, Ph.G., M.D., F.A.C.S., by his associates of the Elizabeth General Hospital on Saturday, June 10th, 1939, at the Winfield Scott Hotel, Elizabeth, N. J., in recognition of his elevation to the Senior Staff of the hospital on his sixty-fifth birthday. The speakers recalled his start as a drug clerk in the institution, his rise to Chief of Staff, and his unique record of having enlisted in two wars,—the Spanish-American War and the World War. His service for thirty years as Trustee of the Public Library was described as evidence of his interest in civic affairs.

Dr. M. A. Shargh served as toastmaster. The speakers included the Honorable Donald H. McLean, member of Congress; Dr. Wells P. Eagleton, of Newark, and Mr. Clayton B. Jones, President of the Board of Managers of the Elizabeth General Hospital. Dr. Horace Livingood was chairman of the committee on arrangements.

THE WOMAN'S AUXILIARY

FUNCTION OF THE WOMAN'S AUXILIARY

By FRANK OVERTON, M.D., Journal Editor

An address before the Woman's Auxiliary to The Medical Society of New Jersey at its annual meeting

It is often stated that the function of the Woman's Auxiliary to The Medical Society of New Jersey is 90 per cent *social*. Sociability is the great magnet which draws medical men together; but that is only the outward expression of their interest. The real work of The Medical Society of New Jersey is that of its serious discussions, and its committee work in planning new activities to meet modern conditions.

No matter how much doctors may differ in their serious conferences, they are enthusiastically social as they meet in the corridors, in the smoking rooms, and in the informal gatherings in the privacy of their rooms. Their sociability is the outward expression of the seriousness of their common interest in the welfare of the profession. Sociability is a *by-product* of a medical society, and not its motivating force.

For the Auxiliary, sociability and entertainment are of value when they inspire the members to serious work. Entertainment soon palls, for it cannot compete with bridge parties, the radio, and the movie show. If the Auxiliary is to flourish, it must have two or three serious objectives. Happily, the Auxiliary has those objectives,—and it will flourish in direct proportion to the extent to which they are developed.

The dominant principle of the Auxiliary is that it shall be *helpful in medical activities*. It can be a leader in those civic activities in which the doctors seek to interest the public,—the great field of *public relations*.

I will speak of three fields in which the Auxiliary can be of essential assistance to the medical profession:

1. The art exhibit.
2. Public health meetings for the people generally.
3. Medical History.

ART

Every physician needs an *avocation*—doing something because he likes to do it, and to do it better than anyone else. One of the most popular features of the radio is the "Hobby-

lobby" hour, which is also one of the most popular features of the side-show at the World's Fair. For example,—one man paints pictures on spider webs—just plain cobwebs,—and mounts them between two panes of glass,—things of beauty and a joy forever, to their maker and to those who view them.

Mrs. Beir has charge of the Art Exhibit at the meeting of the American Medical Association, and is making it a feature that is well worth study. The great difficulty with the exhibit of the A. M. A. Auxiliary has been that it is held at a place remote from the main meeting place.

Last year's exhibit of the New Jersey Auxiliary was held in a side room which no one could find, and yet it was most excellent and inspiring, as was demonstrated by the two photographs which were printed in *The Journal* of March, 1939, page 188.

This year the Committee on Arrangements has assigned the exhibit to a room that is spacious and easy of access.

The wives of physicians know the avocations of their husbands; and have a whole year in which to discover outstanding examples of their art and to persuade the doctors to display their handiwork. The discovery of examples of art handiwork may well be a feature to be discussed in the meeting of the local auxiliaries throughout the year.

PUBLIC HEALTH MEETINGS

A double difficulty with public health education is that of securing:

First, speakers.

Second, audiences.

The forte of the Auxiliary is to be the agent which shall bring the local doctors and the local audiences together.

An abundant supply of speakers is available, provided all that the doctors need to do is to prepare and deliver the address.

There is also an abundant supply of audiences available to greet the speakers. What a local doctor says to the audience is far more effective than the message that is brought by some outsider who has a reputation with a great welfare organization. What the people

want to know is what the *local doctors* think about health schemes.

Every Woman's Auxiliary has a most alluring opportunity to coöperate with the Committee on Public Relations of both the State and the county. Doctors will accept assignments to speak; and lay organizations will welcome the speakers.

MEDICAL HISTORY

The Medical Society of New Jersey had adopted *Medical History* as one of its major projects. The science of the practice of medicine is a slow development and evaluation; and every phase of modern public health work may be clearly traced in the records of The Medical Society of New Jersey. This year, for the first time, a mass of material has been accumulated which is shown in the exhibit of the Auxiliary. This display is not spectacular; but it records the details of medical movements out of which there have come the varied activities of thirty active committees of the State Society. Every one of the present activities had its beginnings scores of years ago, and even dates back to 1766 when the Medical Society was founded—the oldest medical society in the United States.

Composing the medical history of New Jersey must necessarily be done in two phases:

1. The collection of *isolated facts*, particularly those recorded in the Transactions of the State Society and those of the county societies.
2. Arranging the isolated facts in each particular activity, so as to make a *connected story*.

I will call your attention to some of the items that are displayed in the exhibit.

THE RECORDS OF THE PRESIDENTS

Here are three books about the 154 Presidents of The Medical Society of New Jersey. These contain the salient facts that are known about each President:

- When he was born, and died.
- Where he lived.
- The source of the information.
- Where his portrait may be found.

The particular line of work which he promoted, etc.

The information regarding about twenty-five of the Presidents is meager, and sometimes entirely lacking. Yet new information is continuously being discovered. To dig out more of this information is a work for which the members of the Auxiliary are peculiarly fitted. Many members belong to the Daughters of the American Revolution. They have done research work in history and biography, and know how to follow up suggestive leads.

This big book contains the record of the attendance of every member from 1766 to 1816—a half century. It also contains the record of the attendance of representatives of county societies up to 1860. Thus you see that the work of collecting records has only just begun; and a still larger field still remains to be cultivated.

This book contains a record of the Fithian family—a chance discovery, but most valuable as a source of information. Dr. Enoch Fithian, who wrote it, was born in 1792 and died in 1892,—one hundred years later. His cousin,—Joseph Fithian, of Woodbury—was the sixty-ninth President of the State Society in 1849, and was connected by family ties with half a dozen other presidents. Read the editorial on page 351 of the June Journal for remarks on the inheritance of medical ability. Several doctors who are now in practice are descended from four to six former presidents—a living demonstration that "Blood will tell".

Lastly, I call your attention to these four books containing the biographies of the present-day leaders in four counties. They were compiled by the Auxiliaries of the four counties, but unfortunately their very great value and importance was not realized until very recently. What the four Auxiliaries have done is a demonstration of the opportunities which confront every Auxiliary in the State.

The fundamental methods of research in the medical history of New Jersey have been amply demonstrated. The Auxiliaries will find new inspiration and justification for their existence if they adopt medical history as a major activity.

THE ART AND MEDICAL HISTORY EXHIBIT AT THE ANNUAL MEETING

By MRS. ADELE M. BEIR, Chairman, Atlantic City, N. J.

Although many fail to sign up, the registration figures offer the only accurate index of increasing interest, by members and their families, in the exhibition of this committee,

and of its importance as a drawing feature during the Annual Meeting.

In 1938, 223 men and 225 women registered in our guest book, making a total of 448.

This year 824 registered, of whom 393 were men, and 431 women. The breakdown of these figures for purposes of comparison shows that the total attendance increased 80 per cent; that of the men 76 per cent and of the women 90 per cent, and that during the last two years the exhibition has attracted approximately as many men as women, whereas formerly it had been of interest mainly to women. As the meeting is held primarily for the men, we are happy that our exhibition may have provided an additional attraction for them, as well as for their women, and so helped to cause increased convention registration and longer stays.

The great coöperation, encouragement and support I have received throughout the year and at the convention has lightened my work and made success more possible, and I am

happy to have this opportunity of expressing my gratitude to the Officers, Board of Trustees and committees of The Medical Society of New Jersey, to the Editor of its Journal, and especially so for their allocation for our exhibition of a room so beautiful, large, well-lighted and accessible to both men and women; to the President of our Auxiliary, her officers and chairmen for the loyal support they have given me; to the chairmen of County Medical History Committees, who have done and presented such fine work; to the Vice-Chairmen and members of my committee, who worked early and late during the meeting; and, most of all, to those members and their families who so unselfishly troubled to show their beautiful and interesting possessions and thus made our exhibition a success.

To all of these goes a share in the happiness and thanks I feel for the success we have had.

THE NEW JERSEY EXHIBIT OF ART AND MEDICAL HISTORY AT THE A.M.A.

Having charge of the preparation of an exhibit of New Jersey Auxiliary work at the exhibition in St. Louis May 15-19, 1939, of the Exhibits Committee of the Woman's Auxiliary of the American Medical Association, of which I also have the honor of being chairman, it naturally was my desire to have the exhibit of our State both attractive and different from the usual one. The collection of data and documents and medical history constituted the main part of our exhibit.

To New Jersey physicians, I would say that you live in the midst of medical history and are used to it; while delegates from most other states have a comparatively recent medical history, and were deeply interested in making notes of our exhibit. There was nothing like ours at the exhibition, and I am sure that in the future our example and work will be copied by other states. In fact, I am not so sure that all of us realize that our recent State meeting was its 173rd and that the first meeting of any State Medical Society in the United States took place in our State July 23rd, 1766.

The following is a list of the articles shown in our exhibit:

1. Articles sent from the executive and editorial offices:

Photostat of the Original Minutes of the First Meeting of The Medical Society of New Jersey, July 23rd, 1766.

Photostat of the first page of the Original Minutes of Somerset County.

Group photo of Fellows of The Medical Society of New Jersey, 1766-1916.

Group photo of the 1893 State Meeting in Asbury Park, with key and members attending.
Booklet on Scientific Programs of the State Society, 1766-1858.

Booklet of Seals of Medical Societies.

Booklet on the Fethian Genealogy.

Three booklets of biographies of Fellows of the State Medical Society, 1766-1939.

Reprint of photos of Officers and Chairmen of Committees, 1938-1939.

Booklet of Committees of The Medical Society of New Jersey, 1938-1939.

Official List Fellows, Officers, Delegates and Members of The Medical Society of New Jersey, 1938; also 1939.

Reprints, "Old Time Country Doctor Shop".

2. Articles by County Auxiliaries:

Atlantic, Burlington, Camden, and Passaic Counties—Books of biographies and portraits, list of families with three or more generations of doctors, Presidents of county societies, etc.

Book on Archives of the County Auxiliary containing photos and biographies of its Past-Presidents.

Passaic:

Its folder, similar to that of Atlantic County.

Burlington:

Its folder, as above.

3. State Archives Committee:

Scrap book.

Folder of Past-Presidents of the State Auxiliary with photos and biographies.

Folder of Auxiliary State stationery of past years.

4. Poster on Health Education by the chairman of that committee.

5. Two photos of the 1938 exhibition of the Art, Hobby and Medical History Committee.

Atlantic County

Reported by Mrs. Samuel L. Winn, Publicity
Chairman

The final meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at the Ambassador Hotel, Friday evening, May 12, 1939, with Mrs. Andrew Smith presiding, and twenty-five members present.

The yearly reports were read by the officers and committees.

During the evening the State convention, and co-operation for all its activities were discussed.

The new Board of Officers were officially installed by Mrs. Smith, and the meeting adjourned until the October meeting.

meeting, making a total of forty-six new members for this year, and bringing our membership up to 286:

Mrs. David Sheehan, Newark
Mrs. John V. Reilly, Newark
Mrs. Eugene F. Mullin, Newark
Mrs. A. Elston Fink, Newark
Mrs. Joseph H. Wyatt, Newark
Mrs. Charles Englander, Newark
Mrs. Charles S. Morrow, Newark
Mrs. Arthur C. Hensler, Summit
Mrs. Theodore S. Heineken, Bloomfield

Mrs. Gustave A. Braun turned the meeting over to the new President, Mrs. William D. Minningham, who accepted the office very graciously with a few well-chosen words.

The new officers are: President, Mrs. William D. Minningham; President-Elect, Mrs. Irving Fort; Treasurer, Mrs. S. H. Baldwin; Recording Secretary, Mrs. Louis Schneider; Corresponding Secretary, Mrs. George I. Holmes, all of Newark; directors, Mrs. Sidney Keller, Newark, and Mrs. Frank Bien, Irvington.

Delegates appointed to the meeting of the State Auxiliary, June 5 to 8, at Atlantic City, are: Mrs. Gustave A. Braun, Mrs. Frank S. Forte, Mrs. Sidney Keller, Mrs. Anthony Ambrose, Mrs. Frank Bien, Mrs. Richard Staehle, Mrs. E. D. Newman, Mrs. Francis Kerns, Mrs. Harry Comando, Mrs. George Scheller and Mrs. Manfred Kraemer.

Chairmen appointed by Mrs. William D. Minningham are:

Program, Mrs. Don A. Epler; membership, Mrs. Anthony Ambrose; public relations, Mrs. H. Roy Van Ness; ways and means, Mrs. E. A. Flynn; hospitality, Mrs. Sidney Keller; publicity, Mrs. Jesse Theodore Glazier; printing, Mrs. William D. Crecca; legislation, Mrs. Manfred Kraemer; widows and orphans, Mrs. George A. Scheller; medical history, Mrs. Harry Comando; historian, Mrs. Robert R. White; bulletin, Mrs. Frank Bien; telephone, Mrs. Francis J. Kerns; art and hobbies, Mrs. E. P. Cardwell; clippings, Mrs. Samuel H. Jesserun; hostess, Mrs. Richard Staehle; cheer, Mrs. Charles H. Schneider; official typist, Mrs. B. J. Silverstein, and advisory board, Mrs. Gustave A. Braun, Mrs. Charles F. Rathgeber and Mrs. Frederick G. Shaul.

A meeting of the new board will be held on Friday, May 26th, at which time Mrs. William D. Minningham, the new President, will entertain the members at a luncheon at the Crestmont Country Club.

Camden County

Reported by Mrs. George R. German

The annual Spring Luncheon of the *Woman's Auxiliary to the Camden County Medical Society* was held on Thursday, May 4th, at Tavistock Country Club with Mrs. H. Wesley Jack presiding. The program consisted of a talk, "Fascinating Literature", by Mrs. George Emerson Barnes, of Philadelphia; and selections by Miss Blanche Hubbard, harpist of the Philadelphia Music Club.

Officers for the coming year were elected:

Mrs. Max Weiman, President
Mrs. Lawrence Glover, President-Elect
Mrs. Oram R. Kline, First Vice-President
Mrs. George B. German, Second Vice-President
Mrs. Harold V. Barnshaw, Third Vice-President
Mrs. Lester R. Wilson, Treasurer
Mrs. Kenneth MacAlpine, Recording Secretary
Mrs. William Braun, Corresponding Secretary
Mrs. H. Wesley Jack and Mrs. O. W. Saunders, Directors for three years

Mrs. O. W. Saunders, Hospitality Chairman, was in charge of arrangements.

Essex County

Reported by Mrs. Frank S. Forte

Dr. Chester R. Ulmer, of Gibbstown, was the guest speaker at the annual business meeting and luncheon of the *Woman's Auxiliary to the Essex County Medical Society* on Monday, May 22nd, at L. Bamberger & Company. His topic was "How to Get Sick".

While keeping his audience laughing with tales of incidents in the life of a country practitioner, Dr. Ulmer pointed out there are still many unnecessary physical risks taken by persons. As contributing to heart disease, he mentioned the habit of hurrying, running for trains, and too short periods allowed for sleep.

Mrs. Gustave A. Braun, the retiring President, who presided, was presented a past president's pin by Mrs. Don A. Epler, President of the State Auxiliary.

Reports of the year's activities were presented by the retiring officers and chairman.

Mrs. Don A. Epler, membership chairman, presented the names of nine new members at this

Somerset County

Reported by Mrs. Charles F. Halsted

The regular meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held Thursday evening, June 8th, 1939, with Mrs. Edgar T. Flint presiding, and six members present.

Reports were received from Mrs. Albert Pigott and Mrs. Launcelot Ely, who gave some of the highlights of the State Convention. Mrs. Ely also reported a bit of Medical History.



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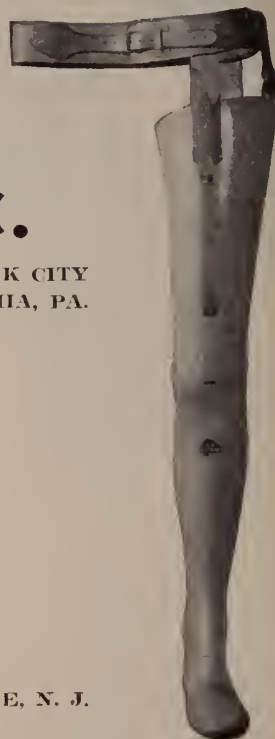
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FRACTURES & TRAUMATIC SURGERY—Ten Day Formal Course September 25. Informal Course every week.

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BELMAR	William T. Lins, 1500 F St., cor. 15th Ave.	Belmar 559
BERNARDSVILLE	Hemmendinger Pharmacy, 12 Mine Brook Rd.	Bernardsville 78
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CLIFFSIDE	Louis C. Ghiosay, 639 Anderson Ave.	CLiffside 6-3834
CRANFORD	J. Walter Seager, 103 Union Ave. N.	CRanford 6-0700
EAST ORANGE	Bell Drug Co., 382 Main St.	ORange 3-7051
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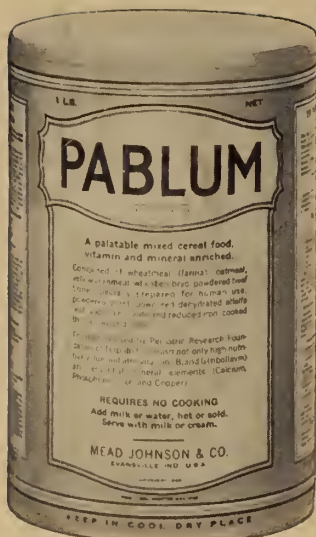
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ARTHUR W. MAGEE, *Commissioner*
State House Office Building, Trenton
Tel. 2-2131, Ext. 208

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CLARENCE L. ANDREWS	Atlantic City
THOMAS MCG. BRENNOCK	Jersey City
WILLIAM J. CARRINGTON	Atlantic City

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JOSEPH F. LONDRIGAN	Hoboken
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Meetings at Trenton at 11:00 a. m. on October 1; December 3; February 18; April 14

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JULIUS LEVY Newark
HENRY B. ORTON Newark
ELBERT S. SHERMAN Newark
C. BYRON BLAISDELL Long Branch
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L. CHARLES ROSENBERG Newark
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Hard Filled Capsule Production

1 ASSAY OF MATERIALS—Ingredients to be used in a capsule formula are first individually assayed.



2 WEIGHING AND MIXING—Drugs are weighed and mixed by trained operators under the supervision of pharmacists.



3 CONTROL—Before powder is put into capsules, the control laboratory assays samples of the mixture to make sure that drugs are uniformly blended and that the contents of each capsule are according to label statements.

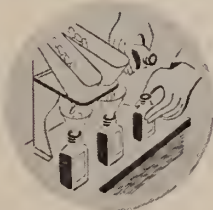


4 CAPSULATING—Specially designed machines, operating in air-conditioned rooms, separate the cap from the body of the capsule and press in the formula mixture. Another operation replaces the cap.

5 POLISHING AND INSPECTION—The final production operation consists of polishing the capsules. They are then inspected for possible imperfections.



7 PACKAGING—Capsules are packaged by machine in air-conditioned rooms.



6 CONTROL—The control laboratory makes a final assay before the capsules can be released.



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Believing that the present units and the standards of reference upon which they are based will be of interest, they have been tabulated and defined:

Vitamin A

The standard of reference (1) is a solution of purified beta-carotene in an inert oil, of such concentration that one gram of solution contains 300 micrograms (0.300 mg.) of beta-carotene. The International Unit of vitamin A is the vitamin A activity of 2 mg. of the standard solution, or 0.6 micrograms of beta-carotene.

Vitamin B₁

The reference standard (2) is the International Standard preparation of thiamin chloride. The International Unit for vitamin B₁ is the antineuritic activity of three micrograms (3 γ) of the International Standard.

Vitamin C

The reference standard (1) for vitamin C is a specified sample of crystalline levo-

ascorbic acid. The International Unit for vitamin C is the vitamin C activity of 0.05 mg. of this standard.

Vitamin D

The reference standard (1) for vitamin D is a solution of irradiated ergosterol, prepared under specified conditions at the National Institute for Medical Research (London). The International Unit for vitamin D is the vitamin D activity of 1.0 mg. of this standard solution.

The International System of expressing vitamin values will undoubtedly soon become official for all authoritative agencies which concern themselves with the establishment of vitamin standards and units. Reference standards for riboflavin and nicotinic acid—both of which are of significance in human nutrition—have not been defined. However, the use of units such as micrograms or milligrams of the crystalline compounds to express riboflavin and nicotinic acid values is becoming increasingly prevalent.

The use of vitamin units of definite value permits correlation of various phases of vitamin research, particularly those phases relating to the vitamin contents of common foods and to the quantitative human requirement for these essential food factors. Although vitamin supplementation of the diet may be desirable under certain circumstances, it is apparent (3) that a well planned mixed diet is most suitable for supplying optimal quantities of the vitamins along with the other essential nutrients. The established vitamin values of canned foods (4) serve as an indication of their usefulness in formulating such diets.

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- (1) 1935. Nutrition Abstracts and Reviews, 4, 705.
- (2) 1938. League of Nations Bulletin of the Health Organization, 7, 882.
- (3) 1938. J. Am. Diet. Assn., 14, 1.
- 1938. J. Am. Diet. Assn., 14, 8.

- (4) 1935. J. Home Econ., 27, 658.
- 1935. J. Nutrition, 9, 667.
- 1938. J. Am. Med. Assn., 110, 650.
- 1938. Nutrition Abstracts and Reviews, 8, 281.

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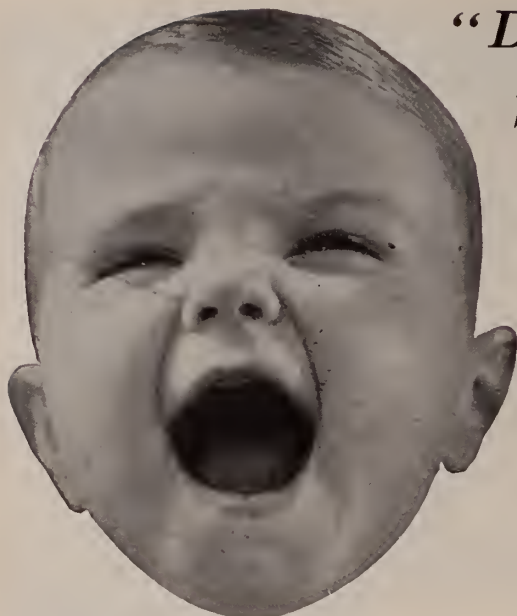


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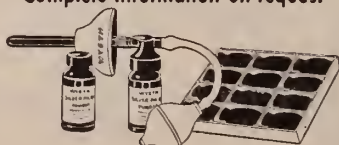
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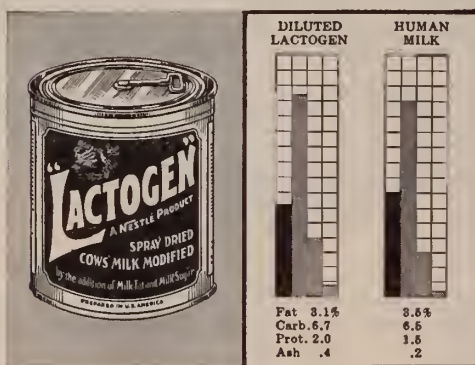
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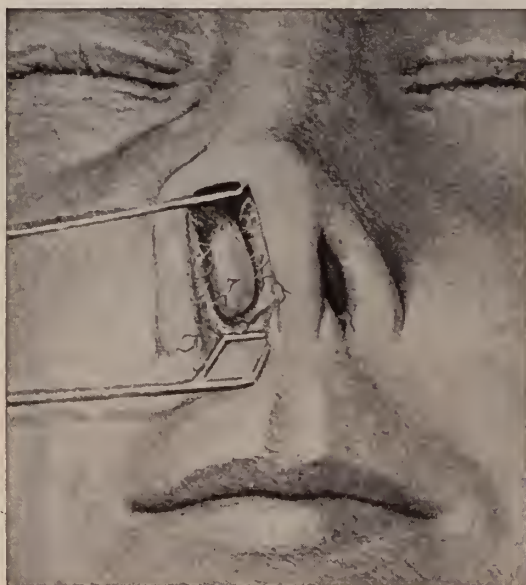


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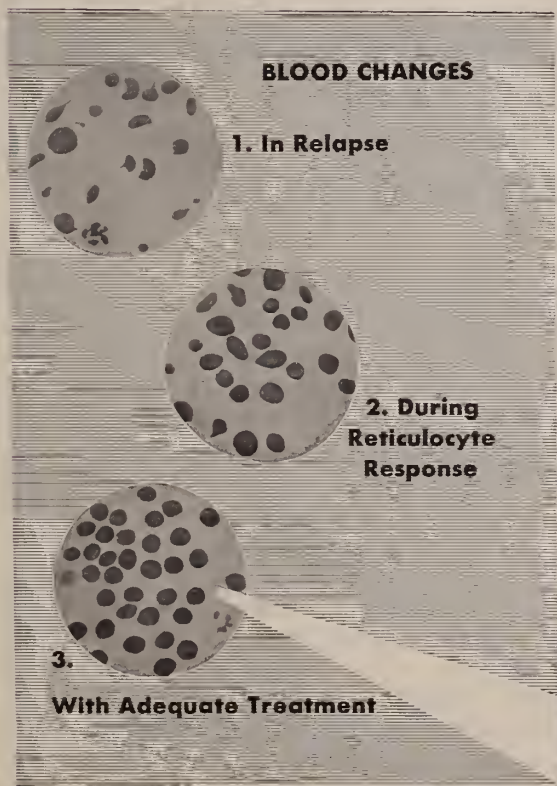
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- ☐ Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245—"Pharmacology of Inflammation: III. Influence of Hygroscopic Agents on Irritation From Cigarette Smoke."
- ☐ N. Y. State Jour. Med. 1935, 35-No. 11,590—"Irritating Properties of Cigarette Smoke as Influenced by Hygroscopic Agents."
- ☐ Laryngoscope, 1935, XLV, No. 2, 149-154—"Some Clinical Observations on the Influence of Certain Hygroscopic Agents in Cigarettes."
- ☐ Laryngoscope, 1937, XLVII, 58-60—"Further Clinical Observations on the Influence of Hygroscopic Agents in Cigarettes."

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FRANK OVERTON, M.D., Dr. P.H.

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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

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AUGUST, 1939

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EDITORIAL

The New Administration

One must be an executive secretary or an editor to appreciate the immense amount of information which flows through the Executive Offices of The Medical Society of New Jersey. Each administrative year is a unit of experience and progress. Each officer assumes his duties with a certain amount of knowledge and zeal, knowing that he has a year in which to formulate his ideas and to put them into practice.

The new system of administration requires each chairman to state his objectives clearly and concisely at the very beginning of his administration; and then at its close, to compare them with the results that have been accomplished. By this system, no officer is overburdened with work, or runs the risk of its becoming conventionalized. The surest way to secure the enthusiasm of a worker is to give him a year of office, and then turn over his work to another. But the fact remains that once he is initiated into a new project, he carries his enthusiasm and experience into new fields, and yet he remains a mentor and adviser

to his successor in office, while he devotes his energies in a fresh field of endeavor. The leadership which The Medical Society of New Jersey has attained is largely the result of a rotation in office by which each member of a committee engages in new duties, with an optimistic outlook.

The Medical Society of New Jersey is fortunate in having one-third of its members in active service on some committee, either State or county,—and the fields are so varied and extensive that every member has the opportunity to render essential service.

Service on an active committee is a training school from which there is no graduation, but only advancement into new fields of service and honor.

The conditions under which the new administration assumes office are the most favorable in the history of the Society. The past decade has been years of planting and cultivation. The harvest during the past year has abundantly justified the efforts of the husbandmen whom their successors will delight to emulate.

The Printed Transactions

A characteristic of the sessions of the House of Delegates is its method of conducting the administrative business of the Society in which it is a leader among the State Societies. Its business is transacted in three steps or stages.

1. The annual reports of the committees are published in *The Journal* a month in advance of the meeting, so that every member has a copy.

2. The appointment of reference committees to whom the reports and all motions on them are referred. Each committee is assigned to a room where any member may go and express his opinions free of interruption or interference, and be assured of a respectful hearing. This feature promotes satisfaction and harmony. The result is that the meeting room of the House is always filled, and there is plenty of time for the consideration of the more important projects.

3. The publication of the proceedings in a summarized form in which the decisions are clearly recorded, while the roundabout roads of reaching those decisions are eliminated.

It was formerly the custom to print verbatim every word that was recorded by the stenotypist;—and then there were frequent requests to change the crudities of expression spoken in the heat of debate. Each year the Publica-

tion Committee has exercised its prerogative of editing the remarks so that they shall appear in a form that can be readily grasped.

This year the editing has been done to a greater extent and more efficiently than ever before. Debates have been eliminated, not because of any lack of value, but because only those shots which hit the mark have been recorded.

The transactions are more concise and readable than ever before, and by the use of cross-references, all decisions and their reasons may be easily traced. This characteristic is fully appreciated by only those who have had to read through interminable pages of debate in order to find out what the real decision was, or if any at all had been reached.

This method was not adopted from any lack of appreciation of the contents of the debates on the floor of the House. Four copies of the stenotypist's notes were made this year for the use of the higher officers, and one of the copies is deposited in the Executive Offices where it may be consulted by any member at any time.

The printed Transactions contain all the decisions of the House in concise, readable form. If any one wishes to know every word that was actually spoken on the floor of the House, he can read it in the stenotypist's copy that is preserved in the Executive Offices.

Records of the Annual Meeting

This year, for the first time, a complete set of the official records of the Annual Meeting has been collated and placed on file in the Executive Offices.

The process of preparing, editing, and printing the official records has been as follows:

1. REPORTS OF THE OFFICERS AND COMMITTEES

- A. The reports of all the committees were prepared early in April.

Printer's proofs were sent to each of the chairmen, who discussed them with his committee at a general meeting held in the Stacy-Trent Hotel, Trenton, on April 16, 1939, according to a plan announced in the April Journal, page 194, and the May Journal, page 345.

- B. The approved reports were printed in the May Journal, pages 257-330; and a reprint was sent to each member of the House of Delegates.

A list of the Reference Committees and their assignments was also printed in the May Journal, page 327, and also in the reprints.

2. RECORDING THE PROCEEDINGS OF THE HOUSE OF DELEGATES

- A. At the House of Delegates, each officer and committee chairman was permitted to submit a written *supplementary report* covering the events which occurred between April first and June sixth—the date of the meeting of the House.

B. A verbatim report of all the details of the proceedings of the House of Delegates was taken by Miss Ansell of the Master Reporting Company, 51 Madison Avenue, New York City, who has served the Society in a similar capacity for several years. Miss Ansell was under the direction of the Secretary of the Society, Dr. Alfred Stahl, and was assisted by Miss Katz, Secretary to the Editor. By this coöperation a copy of every supplementary report and of the written report of every Reference Committee was secured and preserved,—the name of every speaker was correctly recorded. This was a record achievement, and will forestall legal complications.

C. A staff of clerks from the Executive Offices was on hand to typewrite the reports of the Reference Committees, and attend to all the numerous details of preserving and filing accurate records of all the proceedings.

3. PREPARING THE PROCEEDINGS FOR PUBLICATION

A. Ten days after the annual meeting, four copies of the verbatim reports taken by the stenotypist were delivered at the Executive and Editorial Offices, and were distributed as follows:

- One copy to President Carrington;
- One copy to President-Elect Hawkes;
- One copy to Secretary Stahl; and
- One copy was retained by the Editor.

B. At the same time, a complete set of the supplementary reports, and the written reports of the Reference Committees were also delivered to the Executive and Editorial Offices. Several copies of all these reports were made and were delivered to the same officers to whom the stenotypist's record had been given.

C. The Editor, with the assistance of the Editorial Secretary, made an abstract of all the recorded proceedings; numbered the paragraphs; and inserted cross-references so that every item could be readily located at any future time.

Copies of the prepared abstract were made and were distributed to the same officers who received the stenotypist's notes.

The objective in making the abstract was to include every motion and the action taken on it; but to give only brief summaries of the

addresses and debates leading up to the action.

D. The abstract was set in type, and corrected proofs were given to each of the same officers.

E. The approved abstract was printed, and will be mailed to every member as a supplement to the August Journal.

PRESERVING THE ORIGINAL RECORDS

A large manila envelope was secured, and in it was placed the following original records:

1. The reports of the officers and committees that were reprinted from the May Journal.
2. The two envelopes containing the original manuscripts of the supplementary reports and those of the Reference Committees.
3. The Editor's copy of the stenotypist's record of the proceedings of the House of Delegates, containing full reports of the debates, and the decisions of President Carrington, the presiding officer.
4. Three copies of the official program of the annual meeting.
5. The original manuscript reports of the officers and committees of the Woman's Auxiliary.
6. A copy of the supplement to the August Journal, containing the printed abstract of the proceedings of the House of Delegates.

The envelope containing all these records was deposited in the Executive Offices where its contents are available for examination by any member who wishes to ascertain the details of any part of the proceedings of the House of Delegates.

RECORDS IN THE JOURNAL

Every member of the Society has received the serial copies of the current numbers of The Journal containing the reports of work already done, and suggestions for its expansion during the coming year. It is to the personal interest of every member to preserve these Journals for future reference. Every Journal is perforated for the insertion of brass staples which may be obtained at any stationery store. This is an easy and efficient method of binding the Journals in volumes for future reference. Only from the Journals can a member always have available the information concerning every phase of the Society's activities.

Industrial Injuries and the Physician

For the past few years the Workmen's Compensation Committee in its annual report to the House of Delegates has recommended that changes in the medical provisions of the Workmen's Compensation Act be proposed by The Medical Society of New Jersey.

The questions involved, however, have been such that it was feared that conflicting interests of groups within the medical profession would make general agreement on details difficult. It was felt that it would be unwise to suggest amendments to the Act unless some common ground could be reached among ourselves as a basis for offering changes.

For this reason a meeting was held at the Executive Offices of the Society on July 30th. Invitations to this meeting were sent to representatives of all of the groups of our Society who were interested in compensation practice, either directly or indirectly.

About sixty physicians were present, representing the following groups:

1. The Advisory Committee on Workmen's Compensation.
2. The Advisory Committee on Contract Practice.
3. The Advisory Committee on Industrial Health and Hygiene.
4. Similar committees of County Medical Societies and officers of County Medical Societies.
5. The New Jersey Association of Industrial Physicians and Surgeons.
6. Physicians interested in compensation practice who are not members of the Association of Industrial Physicians and Surgeons.
7. Physicians not personally interested in compensation practice.

In his opening remarks, the President stated the general purpose of the meeting, and that the basis for discussion would be the four specific recommendations of the Workmen's Compensation Committee, which were approved by the House of Delegates on June 8, 1939. These recommendations were as follows:

1. The injured or diseased worker should have the right to select his own physician, providing

proper safeguards were included protecting him against unqualified or incompetent services, and preserving unto his employer the right of consultation, etc.

2. Your committee was of the further opinion that all doctors employed in compensation work by the State should be full-time employees of the Department, and not be permitted to engage in any other work.

3. Your committee were in agreement, or, if not in full agreement, in near accord, that all clinics conducted by insurance carriers and manufacturers should cease caring for injured or diseased workers, except as first aid or emergency treatment.

4. Your committee felt that the act should be changed as it relates to hernia, in that the payment for services to physicians in the cases of hernia should be separated from hospital bills, and that an allowance of \$100.00 should be made a physician for operating a case of hernia.

Dr. Comando, Chairman of the Workmen's Compensation Committee, was then asked to preside.

The Chairman first called upon Dr. McBride to open the discussion. Dr. McBride was Commissioner of Labor for the State of New Jersey from March, 1924, to March, 1928. He stated that there are undoubted abuses in the operation of the Act, and he believed that the four recommendations of the committee should be written into the Law. He emphasized that the only purpose of the Law was the protection of the employee, and stated that recommended changes in the Law made from the medical point of view must also consider the viewpoints of employers, insurance companies, the Department of Labor, and the public.

The meeting was then opened to general discussion.

Discussion centered about the first recommendation, namely, that the "worker should have the right to select his own physician". Representatives of every group present entered into the discussion, and every possible angle both for and against free choice was brought out. At the end of this discussion, although no vote was taken, it was evident that recommendation number one met with almost unanimous approval.

Recommendation number two was approved without much discussion.

Recommendation number three was dis-

cussed fully, the prevailing opinion being that clinics conducted by manufacturers should be approved, the workmen being given free choice between being treated at these clinics or at physicians' offices, but that clinics conducted by insurance carriers for treatment of other than their own employees be disapproved.

After discussion of recommendation number four, it was evident that the proposal to separate the bills for physicians' services from those of the hospitals met with the approval of all those present, but there was general disapproval of a fee schedule.

The meeting as a whole was most satisfactory. The broad-minded approach to the subjects discussed demonstrated the fair-minded-

ness of the medical profession. Representatives of every group advocated not only their own welfare, but also spoke for the interest of all other groups, and all wished to be fair to labor and to industry also. In the minds of all, the welfare of the employee was the paramount consideration.

The result of the meeting is to give to the officers of our Society definite knowledge of the viewpoints of the medical profession as a whole. We can now suggest changes in the Workmen's Compensation Act, confident that these changes will meet with the approval of all groups within the profession.

E. ZEH HAWKES.

The Annual Meeting a Century Ago

The phenomenal success of the 173rd Annual Meeting of The Medical Society of New Jersey influenced the Editor to look up the minutes of the 73rd Annual Meeting, which was held in Joline's Hotel, New Brunswick, on May 14, 1839. At that time the State was divided into sixteen counties, in thirteen of which county medical societies had been formed. Nine county societies were represented by sixteen delegates, but sixteen accredited delegates were absent.

There were also present seven officers, out of the nine on the official list; and also five Fellows, out of eleven who were still living. In all, there was an attendance of twenty-eight physicians, all of whose names were listed with the societies which they represented, as was the usual custom. The minutes fill three and a half pages of the printed records.

The President, Dr. B. H. Stratton, reported that he had forgotten to bring the annual address which he had prepared.

The First Vice-President, J. G. Goble, stated that he had prepared an address for the last meeting, but sickness had prevented him from attending. He was requested to read it at this meeting, but he did not have it with him. The two delinquent officers were directed

to deliver their addresses at the next meeting, which Dr. Goble did on the subject "Empyri- cism".

The reports of the censors showed that in two of the three districts fifteen licenses to practice had been issued by the Society. The fees received were \$225, and the expenses, \$49. (The greater part of the income of the Society was derived from fees paid by licen- tiates.)

The Corresponding Secretary, Dr. S. H. Pennington, reported that he had received a copy of the "Annual Report of Interments in the City of New York" from an unknown source.

The following bills were ordered paid:

B. Olds for 326 copies of the By-Laws, and 100 diplomas (probably for licentiates)	\$66.50
Office of Newark Daily and Sentinel	10.00
N. Palmer, advertising	3.00
B. H. Stratton, President, for wafers	0.62
	<hr/>
	\$89.12

(Wafers were thin discs of sealing wax, used in sealing letters and certifying documents.)

The Committee on Treasurer's Accounts reported that the books were correct, and showed a balance on hand of 17 cents; yet the hotel bill of \$35.75 was ordered paid. (This was probably for dinners for the members, as was the custom.)

A committee was appointed to devise means for replenishing the treasury; and the sale of ten shares of bank stock owned by the Society was authorized.

Dr. A. F. Taylor, Chairman of the Committee on a State Lunatic Asylum, made a report which was accepted, and the committee

was authorized to memorialize the Legislature on the subject.

Dr. L. Condit reported that a national medical convention to revise the Pharmacopeia was to be held in Washington in 1840. Drs. L. Condit and William Forman were elected delegates to attend it.

Officers were elected, and reporters were appointed whose principal duties were to report on health conditions in the several counties.

These minutes seem meager in the light of those of the 173rd Annual Meeting; but considering conditions in 1839, the Society was remarkably active.

Optometry and the Eyes of School Children

School physicians and nurses discover many cases of defective vision, and advise the parents to take the children to a physician for diagnosis and treatment. This advice is important, because many cases of defective vision are caused by pathological changes in the eye itself, or some disturbance elsewhere in the body,—conditions which an optometrist is incapable of diagnosing or treating. The physician is the proper one to decide whether an individual case needs the services of a specialist and what kind of a specialist.

Furthermore, in many cases of refractive error, especially in young children, no one can make an accurate examination without the aid of a cyclopegic ("Drops"),—a procedure which optometrists cannot legally employ.

Since an accurate diagnosis is a necessary preliminary to any treatment, the school nurse is legally required to advise the parents of a child to have a diagnosis made by a licensed physician, for only he is empowered to make a pathological diagnosis and to prescribe drugs and operations for relief.

The Y. M. C. A. in Health Education

One of the objectives of a county medical society is to serve in an advisory capacity on health matters to lay organizations within the county.

County medical societies in New Jersey may have a definite opportunity to do this in the near future. The State Health Education Council of the New Jersey Young Men's Christian Association is recommending to each community unit throughout the State that the local Y. M. C. A. unit communicate with the local county medical society secretary to re-

quest the county medical society to act in an advisory capacity on health matters to the requesting organization.

A "Health Week" is to be an annual project of the New Jersey Young Men's Christian Associations. The excellent results of this 1939 Health Week in Jersey City are found on page 519. The Y. M. C. A. units are already planning for the 1940 observance of their Health Week. The active coöperation of county medical societies will help them to achieve good results.

ORIGINAL ARTICLES

FACTORS DETERMINING LOCALIZATION OF ORGAN TUBERCULOSIS

By SAMUEL BERG, M.D., Newark, N. J.

From the laboratories of Newark City Hospital, Newark, N. J., Dr. Harrison S. Martland, Director, and of Sea View Hospital, Staten Island, N. Y., Dr. George G. Ornstein, Director. Lecture delivered before Essex County Anatomical and Pathological Society at Academy of Medicine, Newark, N. J., on October 22, 1936. Abbreviated for publication.

Despite the marked decline in the morbidity and mortality rates of human tuberculosis throughout the world, it still ranks as one of the major calamities of mankind. The efforts expended in the study of this infection since the discovery of the causative organism are tremendous, yet much remains to be learned. One of the questions still unanswered is why certain organs, such as the lung, are the seat of tuberculous disease more often than other organs such as the intestine; why certain portions of some organs, such as the kidney medulla, are more often diseased than other portions of the same organ, as the kidney cortex; or the epididymis more often than the testis. Many theories have been advanced to account for this peculiar predilection of tuberculous disease, but none seems to fit the facts quite as well as the theory to be offered presently.

An understanding of the terms *infection* and *disease* as applied in this disease are necessary. Terminology, like everything else, is relative, and a term might have different meanings to different persons. A pathologist looks upon disease as a process by which noxious influences produce a lesion; to a clinician disease means also that the lesion is extensive enough to disturb the well-being of the individual. From a pathological viewpoint the distinction is unscientific; from a clinical viewpoint it is practical, important, and satisfactory. Since this paper deals with the clinical aspects of tuberculosis, *infection* will mean the existence of a lesion too small to cause concern, whereas *disease* will mean the existence of lesions large enough to impair the general health.

Koch must be credited not only with discovery of the cause of tuberculosis, but also with

discovery of its fundamental pathogenesis. Koch's phenomenon¹ bears review. Intracutaneous injection of a moderate dose of tubercle bacilli into a guinea pig produces a slowly developing nodule at the site; with the onset of allergy after a variable interval of time, the nodule undergoes caseous necrosis and ulceration, and this ulcer remains unhealed until the death of the animal. Now, if a second dose of moderate size is injected elsewhere into this allergic animal before its death, caseation and ulceration take place within a few days, but the ulcer heals. If a very small number of bacilli is used to produce superinfection, the lesion is almost entirely proliferative and remains a nodule without ulceration; of course, with intervening doses the proportion of proliferation-exudation-caseation varies. Furthermore, the drainage lymph nodes show marked caseous changes with the primary infection; whereas they are relatively little involved with the superinfection. The fundamental concepts as elaborated by Koch have remained unchanged except for minor differences uncovered in the course of recent investigations.

With Koch's phenomenon as a basis, the thesis on organ localization of tuberculous *disease* will now be presented by a series of postulates.

POSTULATE I.

Living tubercle bacilli invading a non-tuberculous body disseminate before the onset of allergy like parenterally-introduced particulate matter or colloid suspensions.

Experiments in animals show that particulate matter, such as India ink, or colloidal suspensions such as dyes, when injected parenterally, can be recovered in a short time and in varying degree in almost every organ. The

same general dissemination has been observed in humans after injection of various substances therapeutically and experimentally.²

Of particular interest in this respect are the classic and also fundamental experiments of Krause,³ who showed that subcutaneous injection into guinea pigs of tubercle bacilli results in general dissemination within a few days. The organisms travel through lymphatic channels until they reach the thoracic duct, pass through the venous channels to the right heart, thence through the pulmonary circulation to the left heart, and finally disseminate by way of the arterial system. Of course, the rapidity and degree of dissemination depend on several factors, the chief of which are the type and amounts of particulate matter and the avenue of parenteral introduction.

Too close an analogy cannot be drawn between the results in animal experiments and the course of events in human infections, especially when dealing with tubercle bacilli, because the size of the experimental dose in animals is much greater in proportion to body weight than the usual infecting dose in humans; because of differences in anatomic structure such as pulmonary lymph nodes and vessels; and because of differences in species resistance. But the Lubeck disaster, which is the nearest approach in humans to experimental conditions in that living tubercle bacilli of the human type were administered parenterally and per os in infants in huge doses, has offered evidence that the general dissemination of tubercle bacilli is the same in animals and humans under corresponding conditions.⁴

There are two vital differences between inert material and tubercle bacilli. First, the bacilli can and do gain parenteral entrance to the non-allergic body by mere contact (readily through mucous membrane, less readily through skin unless broken). Secondly, in susceptible animals they regenerate, so that the number of organisms present at the time of allergy is many times greater than the original dose.

With inert material, neither occurs.

POSTULATE II.

Tubercle bacilli concern themselves with cells of mesenchymal origin, so that the degree of

tissue or organ infection (not disease) will depend on the number of mesenchymal or histiocytic cells present therein.

The cells of mesenchymal origin that show phagocytic activity have been grouped by Aschoff² into a functional unit under the term *reticulo-endothelial system*, and can be identified more accurately by this physiological attribute than by structural appearance in stained preparations. Various names have been applied to them, such as histiocytes, fixed phagocytes, reticulum cells, clasmatocytes, macrophages, polyblasts, etc. They take up experimentally introduced acid-aniline dyes, lithium carmine, India ink, saccharated iron; therapeutically introduced colloidal gold and lead; metabolic products such as degenerated blood cells and lipoids; and products of infection such as malarial pigment, and, of present importance, tubercle bacilli. These phagocytic cells are present in practically all tissues in varying numbers.

On the basis of such functional studies in experimental animals and in humans, the *histiocytic cell content of the various organs* can be grouped roughly as follows:

MOST	MODERATE	LEAST
Bone marrow	Skin	Muscle
Liver	Prostate	Epididymis
Lung	Tube	Meninges
Lymph nodes	Kidney	Ovary
Spleen	Adrenal	Pancreas
	Serous membranes	Testis
		Intestine
		Thyroid

In the human body, the incidence of tuberculous *infection* is somewhat similar to the grouping above; and it must be particularly noted that it is tuberculous *infection*, not *disease*, that varies with the number of phagocytic cells present in the various organs as listed.

Tubercle bacilli that have gained parenteral entrance into the non-allergic body are attacked at first by polynuclears, but this reaction is evanescent and unimportant. Soon thereafter the histiocytes phagocytize the bacilli, which behave like foreign bodies due to their lipoid content. A foreign body reaction ensues, and the histologic tubercle is formed by proliferation of the fixed and circulating mesenchymal

cells. This is the essential lesion of tuberculosis.⁵ Since the localization of bacilli and the cytological response to the bacilli depend on mesenchymal cells, one would expect to find discrete tubercles in numbers varying with the histiocytic cell content of the organs as listed. In routine autopsies on patients dying from chronic ulcerative pulmonary tuberculosis, during which tubercle bacilli invade the blood stream, miliary tubercles are found to vary in incidence in the organs in about the same order of frequency. So it appears that tuberculous infection varies with the histiocyte content of the organs.

As White states,⁶ "With the knowledge that the epithelioid cell is the outstanding feature of the early formation of tubercles in the body and that the characteristics of this cell are similar to those described for the monocyte (a mesenchymal derivative), one would expect that in the animal body the tubercles would form wherever this cell has its greatest round of activity. This is actually the case, for in the spleen and lungs and lymph glands and parts of the bone marrow we have by far the greatest expression of tubercle infection, and these are the regions of greatest frequency of this type of cell. They are, however, probably found any place where blood and lymph flow and where mesoblast exists, and chance may land such a tubercle-laden cell in any spot, but the maximum location still corresponds with the maximum round of activity."

POSTULATE III.

Tuberculous disease is caused by the rapid dissemination of large amounts of tubercle bacilli or protein among allergic cells.

It is well to recall Koch's finding that infections in allergic animals due to small numbers of tubercle bacilli cause proliferative or productive reactions, whereas large numbers produce exudative and caseous lesions. Another experiment duplicates these findings. If an allergic animal is injected intravenously with a light suspension of discrete bacilli, the lungs will show tubercles constituted mainly of proliferative cells, giant cells, and reticulum, and very little if any exudate. The response in a similar animal which has received an intra-

venous injection of clumps of bacilli will be larger tubercles in which the reaction is mainly exudation, central necrosis is common, and proliferation is relatively slight. These differences are noted regardless of tissue involved. If the injections are made into the left ventricle, both types of tubercles develop in other organs also.

Analagous conditions are seen in humans.⁷ The discrete exudative lesions with caseous centers in the liver, the so-called "soft" tubercles, contain clumps or large numbers of bacilli; whereas the small, discrete tubercles composed mainly of epithelioid cells and one or more giant cells but relatively few round cells, the so-called "hard" tubercles, contain very few organisms in their centers.

This leads to the concept so ably presented by Rich⁸ and his collaborators. From animal experiments it was found that tuberculous meningitis could not be caused by injection of bacilli into the vascular system, but only by intrathecal injection. Careful autopsy technic in humans then showed that tuberculous meningitis was caused by rupture of a preëxisting caseous focus in nerve or bone tissue into the arachnoid. The more careful and thorough the technic, the more often will one find an older local lesion emptying its caseous contents and bacilli into the meningeal spaces; this fact is so striking that one would be reasonable, even justified, in assuming that tuberculous meningitis is always caused in the same manner. Then, as Rich⁸ points out, "What is true of the meninges is equally true of serous cavities in general; without question, in each case a local tuberculous focus must have ruptured into the serous cavity—a caseous subpleural lymph node, a focus at the surface of the lung, or a cold abscess in association with vertebral tuberculosis, discharging bacilli into a pleural cavity; a caseous focus in bone or cartilage discharging into a joint; a tuberculous fallopian tube or caseous mesenteric lymph node discharging into the peritoneal cavity; a tuberculous lymph node involving the pericardium, or a direct extension from pleural tuberculosis."

The influence of dosage on the type of reaction is seen quite vividly in the skin. Organ-

isms reaching the skin by way of the lymphatics or capillaries can do so only singly or in small clumps, and the early lesions will be discrete and correspondingly small; whereas direct implantation of large numbers of bacilli on the surface will induce lupus vulgaris type of lesion, as seen on the face of infants where the skin is soiled with the discharge from a tuberculous otitis media, or on the thenar eminence of old men who have the slovenly habit of wiping their bacilli-laden mouths with the backs of their hands.

POSTULATE IV.

Tuberculous disease will affect those organs or parts of organs which possess actual or potential spacial structures, where tubercle bacilli or protein can disseminate widely and rapidly.

Whereas the previous postulate was based on observations in animal experiments and human autopsies, the above postulate is an assumption by which an attempt will be made to explain the localization of tuberculous disease in other organs.

The kidney is divided into cortex and medulla. The cortex consists mainly of myriads of glomeruli supplied by a rich vascular system. The medulla consists mainly of parallel ducts of varying size, serving to convey the urine to the pelvis; it is thus a part of the kidney made up almost entirely of spacial structures. If a tubercle were to extend into adjacent tissues in the cortex, it would meet with very fine tubules separated by interstitial tissue; whereas a caseating tubercle extending its activity in the medulla would rupture into good-sized ducts grouped together. Tuberculous disease of the kidney, by which is meant the chronic or ulcero-caseous form as distinguished from tuberculous infection of the miliary or nodular type, is found in its earliest and most extensive stages in the medulla usually near the apex of a pyramid,⁹ where the ducts are largest and so offer easy spacial dissemination. Thus, theory and practice concur.

The testis is a solid organ containing gland-like structures producing spermatozoa; the epididymis is an adjacent part of the generative organ made up of ducts to convey the semen.

Applying the present postulate to these structures, one should expect to find tuberculous disease much more often in the epididymis with its spacial structures, than in the solid testis; and here again a logical supposition is substantiated by actual experience.

The liver is a solid organ with a relatively small number of ducts of any size running through it. Because of this, organ tuberculosis, that is, large, caseous masses, should occur only rarely and only when a tubercle ruptures into a duct, even though the liver is the seat of many tubercles in most cases of chronic ulcerative pulmonary tuberculosis. The fact is that tuberculous disease of the liver occurs infrequently; but when it is seen, one will always find that a large duct has been invaded by tubercle bacilli or protein from a preëxisting caseous tubercle.¹⁰

This postulate will cover tuberculosis in every organ. In general, it indicates that the solid structures will be the seat of discrete tuberculous lesions which can be restrained to the extent that they will not cause lethal disease,—with a few exceptions to be noted later. Obversely, those tissues having actual or potential spacial structures will be the seat of tuberculous disease extensive enough to cause concern; and of course, the greater the number of spacial structures, the higher the incidence of organ tuberculosis.

Now, taking into additional consideration the importance of spacial structures in the localization of organ tuberculosis, the grouping of *organs in order of frequency of disease involvement* would have to be changed from that previously noted to the following:

MOST	MODERATE	LEAST
Lung	Bone marrow	Muscle
Kidney medulla	Lymph nodes	Ovary
Tube	Meninges	Pancreas
Epididymis	Prostate	Testis
		Spleen
		Skin
		Kidney cortex
		Adrenal
		Thyroid

Of course, hard and fast rules cannot be laid down in medicine. The adrenal gland is a solid organ, yet it not infrequently is the seat of extensive caseous changes. It is fairly rich

in histiocytes, and is very frequently the seat of miliary tubercles. These may enlarge by extension or contiguity until enough gland is involved to cause serious if not fatal impairment of function. The same applies to slow destruction of the pituitary, or extension of a tuberculoma of the heart muscle to involve the bundle of His, or some other small but vital tissue. These are exceptional instances. It is possible for a miliary tubercle in the submucosa of the larynx or intestine, as part of a generalized miliary tuberculosis, to extend to the surface and cause gross laryngeal or intestinal tuberculosis by sudden release of groudous material from the ruptured tubercle;¹¹ but this is so infrequent that one is justified in assuming in practice that laryngeal or intestinal tuberculosis exists practically always only in the presence of open pulmonary tuberculosis. Exceptionally, then, the postulate fails to apply, but these exceptions are covered by the following postulate:

POSTULATE V.

Summation of repeated small infections over an extended time produces the same lesions of tuberculous disease as rapid dissemination of large amounts of tubercle bacilli or protein through spacial structures.

Summation is a principle well recognized in physiology, in pharmacology, in bacterial infections. Summation is of importance in the pathogenesis of tuberculous lesions, and in two ways.

One way is by lymph flow. Drainage lymph nodes are severely involved as part of the primary complex of an initial infection; they are much less severely and infrequently affected by lesions developing after the existence of allergy. But the continuous drainage of tuberculous detritus and organisms can and does cause extensive caseous changes in nodes.

The lung parenchyma is the seat of continuous reinfection from lung lesions by reason of the lymph-venous circulation. Existing lung lesions drain into the bronchial nodes, thence into the tracheal and mediastinal nodes, and eventually the organisms pass through the thoracic duct into the left subclavian vein, to the right heart and into the lung by the pul-

monary artery. The lungs, rich in phagocytic cells, retain many of the organisms. It can be understood that this process might persist over a time during which numbers of organisms will be deposited in one area.

The second type of summation results from rupture of a focus of tuberculosis into an end artery, such as in the lung, kidney, heart or any organ which shows wedge-shaped infarcts from emboli or thrombosis in one of their arterial trunks.

So that finally, if the following three factors are considered:—

1. The histiocyte content of the tissues,
2. The anatomic structure with special reference to spacial structures,
3. The afferent blood and lymph supply to the organ;—

then the grouping of the *organs in order of incidence of tuberculous disease* would take the following form:

MOST	NEXT	NEXT	LEAST
Lung	Lymph nodes	Meninges	Ovary
	Intestine	Epididymis	Pancreas
	Serous cavities	Skin	Muscle
	Kidney medulla	Liver	Testis
	Larynx	Prostate	Thyroid
		Tube	
		Adrenal	
		Bone marrow	
		Spleen	

One must agree that the above grouping, based entirely on theoretical premises, corresponds closely enough to the actual incidence of organ tuberculosis in humans to establish the thesis.

The lung stands in a class by itself. Even if it were not the most frequent site of primary and secondary tuberculous infection from without, it would eventually have the highest incidence of infection by reason of the fact that the lymphatics from practically every part of the body drain into its central nodes, and the venous blood from every part of the body (except portal) drains directly into its rich capillary system, and it would thus receive organisms from any systemic lesion severe enough to release them. Furthermore, once the pulmonary parenchyma or the pulmonary lymph nodes are involved, a vicious cycle is set up by drainage of organisms from these lesions through the lymphatics to the left sub-

clavian vein and back again to the lung parenchyma. Once these lesions, regardless of their size, undergo changes leading to release of myriads of bacilli or caseous contents, their easy and rapid dissemination through the exquisite spacial structures of the lung easily makes it the most frequent site of organ tuberculosis.

These factors explain only why certain organs are favored over others in the localization of tuberculous disease; in all circumstances another factor is essential, and that is the presence of large numbers of organisms. Aside

from occasional heavy primary and secondary infections, which undoubtedly are quite exceptional, the existence of large numbers of organisms in any lesion must be due to propagation of tubercle bacilli within the tissues, and this is by far the most important factor in the pathogenesis of tuberculosis. This, however, does not lessen the significance of the anatomic and functional factors concerned in localization; and their consideration should certainly help to elucidate some of the unexplained phenomena of tuberculous disease.

156 Roseville Avenue

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PRIMARY BRONCHO-PULMONARY ASPERGILLOSIS

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Invasion of the lung by the Aspergilli may be more common than would appear from the number of cases reported, for the clinical course of broncho-pulmonary aspergillosis is similar in many respects to chronic pulmonary tuberculosis, and in some cases ascribed to this condition.

Michaeli in 1725 first described the genus *aspergillus*, of the family Aspergillaceae, order Aspergillales, class Ascomycetes. It is a regular inhabitant of the soil, and is one of the most abundant moulds encountered. It has been frequently isolated from cereal products, unmilled grain, hay, and many stock feeds. Certain species of birds, notably the pigeon, are excellent carriers of the disease.

Almost a century ago, Hughes Bennett first described *pneumomycosis*. Virchow, in 1856, described several cases of aspergillosis of the

lung and bronchi. Dieulafoy, Chantmesse and Widal in 1890 described several cases of pulmonary aspergillosis occurring in individuals engaged in the occupation of fattening pigeons. Since this time a number of cases have been recorded in the literature.

Because of its relative abundance in nature, the question of immunity and infection arises. Castellani states that the aspergillus is usually a *saprophyte* but may become a *parasite*. Farmers, feed mill workers, and threshers are more prone to this disease. As illustrated in the classical work of Dieulafoy, Chantmesse and Widal, these workers were heavily infected both by taking the grain in their mouths, and by feeding the infected pigeons.

Moolton points out two conflicting factors, the dose of virulence of the microorganism, and the resistance to the host in the pro-

duction of two types of pulmonary aspergillosis. He describes a "superficial" form in which are included cases of bronchitis, catarrhal or asthmatoïd, which run a fairly benign course, and a "deep" or "ulcerative" form in which the endotoxins of the moulds cause necrosis of the lung tissue analogous to caseation in tuberculosis. These two types are relative and vary with the degree of allergy present.

CASE REPORT

Patient, J. C.; aged twenty-seven years; occupation, farmer.

After a period of threshing oats, the patient in June, 1936, developed a cough which was unproductive. Five months later, he began to expectorate about one ounce daily of thick, greenish-yellow sputum. He went to his physician, and after an x-ray study, the diagnosis of pulmonary tuberculosis was made.

Phrenic paralysis on the right was advised and performed in October, 1936. Symptoms of cough and expectoration continued, and he began to have frequent bouts of streaking and haemoptysis. At times, hemorrhage was so severe that he had to be institutionalized. At no time was the tubercle bacillus isolated.

He was admitted to the New Jersey Sanatorium for Tuberculous Disease December 28, 1938.

Family History—Essentially negative. No known history of tuberculous contact.

Past History—Scrofula as a child, otherwise healthy.

Physical Examination—Well-developed and well-nourished white male, twenty-seven years of age, presenting scrofulous scars one-half cm. to 10-15 cm. in diameter on jaw, neck and left forearm.

Lungs—Impaired resonance with bronchial breath sounds in R. U. L. Fine to medium coarse râles in R. U. L. anteriorly and posteriorly.

Other systems essentially negative.

The laboratory data was essentially negative. Sputum studies for tubercle bacilli were negative on repeated plain smears, concentrates, gastric analysis, and culture.

In view of the negative findings, it was decided to have the patient bronchoscoped to determine nature of the haemoptysis and possibility of aspergillosis.

Bronchoscopic Examination—January, 1939—Professor Louis H. Clerf passed a bronchoscope, and found a small quantity of thick, yellowish secretion in the trachea and both bronchi. The mucosa of the larynx, trachea, and particularly the right bronchus, was found thickened and inflamed. Relatively little change was noted in the left bronchus.

Secretion was aspirated, and a specimen was secured for tubercle and fungus study. The laboratory report of this specimen showed no acid-fast bacilli. Culture for bacillus tuberculosis was negative.

Streptococcus viridans, *Staphylococcus aureus*, *Diplococcus mucosus* were cultured. The culture contained a number of the Genus *Aspergillus*.

COMMENT

It has been noted by observers, the similarity in behavior of this disease to that of tuberculosis. This is particularly true of the "ulcerative" form, which progresses slowly over a number of years. This has rightly been called *pseudo-tuberculosis*. The less allergic cases assume a granulomatous appearance, and eventually heal by fibrosis.

There are intermediary stages. The lesion may be exudative, caseous, pneumonic, or chronic productive as of the tuberculosis classification of Ornstein, Ulmar and Dittler, depending on the virulence and dose of organism and the resistance of the host.

Roentgenographically, these various types of aspergillosis are difficult to differentiate from pulmonary tuberculosis. Therefore, those cases presenting the roentgenographic changes similar to pulmonary tuberculosis, but having a negative sputum for tubercle bacilli should be regarded with suspicion. A careful history and sputum studies will transform a malignant diagnosis to one comparatively benign.

SUMMARY

1. A case of broncho-pulmonary aspergillosis is presented.
2. Pathogenesis of aspergillosis is discussed with certain similarities to tuberculosis.
3. Stress is made of careful history and sputum studies in diagnosis.

I wish to thank Professor Louis H. Clerf for permission to publish his bronchoscopic findings.

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THE NEUROSURGICAL ASPECTS OF THE CRANIAL NEURALGIAS

TRIGEMINAL NEURALGIA, GLOSSOPHARYNGEAL NEURALGIA AND MENIERE'S SYNDROME

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Functional impairment of the cranial nerves is concomitant with various diseases of the central nervous system, and is manifested by the involvement of numerous cranial nerves. Three of the cranial nerves, however, are subject to dysfunction of the individual nerves themselves without any known involvement of any other part of the central nervous system. These nerves are the fifth, eighth, and ninth; and their disordered function results in conditions known as *trigeminal neuralgia*, *Meniere's syndrome*, and *glossopharyngeal neuralgia*.

TRIGEMINAL NEURALGIA

Trigeminal neuralgia was first fully described by Fothergill in 1776. His description is classical, and little can be added to it now.

Nothing is known about the *etiology*, although various theories have been advanced. The pain is always unilateral, and limited to the distribution of the fifth cranial nerve. One or more divisions of the nerve may be affected, but the pain never goes beyond the distribution of the trigeminal nerve on the involved side. In two per cent of the cases, the pain may, at one time or another, become bilateral. In the usual attack, however, the pain never goes across the midline. The pain is described as stabbing, knife-like, or like an electric shock. It is always, then, a *lancinating* type of pain, and is always *paroxysmal* in character, leaving free periods between paroxysms.

Frequently, the paroxysms come in cycles, so that between cycles there may be several months or even years of remission. During the periodic attacks, the paroxysms come every few minutes or occasionally the patient may suffer only a few paroxysms a day; but during the hours of freedom he lives in dread of the next paroxysm. Talking, eating, washing, or exposure to cold air may precipitate an attack. Frequently, paroxysms occur without any stimulation. If one has ever seen a patient

experiencing such an attack, it cannot be mistaken for any other condition, but if one has to rely upon a description of an attack, there may be some uncertainty in arriving at a diagnosis.

DIFFERENTIAL DIAGNOSIS

True trigeminal neuralgia must be clearly differentiated from any other type of pain because of the specificity of its treatment. When the pain is not characteristically that of true trigeminal neuralgia, with the boring, lancinating paroxysmal attacks, one must rule out the paranasal sinuses and teeth as being the offending causes.

There is another group of cases which, for want of a better name, have been called *atypical trigeminal neuralgia*, and these are the most resistant to treatment. Little more is known about the etiology of this group than about the true tic dolooureux of the fifth nerve. When operations for trigeminal neuralgia were first being done, occasional cases were encountered where the patient, despite complete anesthesia of the involved area, continued to complain of the same pain they had before operation, and in some cases the pain was worse. More recently the true character of these atypical cases have been recognized as such, mainly through the efforts of Frasier; and now the neurosurgeons have learned not to submit these patients to posterior root section.

The sphenopalatine neuralgia of Sluder is another cause of facial pain which must be differentiated. However, the differentiation is not difficult. The pain is more often constant, than spasmodic; and is referred to the root of the nose, the eye, and the zygomatic region, occasionally behind the ear and down to the base of the neck. Cocainization of the sphenopalatine ganglion gives immediate relief, and confirms the diagnosis.

On examination of the patient there are no

objective findings except the typical reaction of the patient during the attack. Frequently the patient may have a *trigger zone*. Touching such a zone immediately precipitates a typical paroxysm of pain. The trigger zone is most frequently located near the angle of the mouth, near the base of the nose, or sometimes on the buccal mucosa. There is never any alteration in sensation; and if on examination any sensory findings are elicited, one must immediately look for some *organic central nervous system* disorder,—in most cases tumor, either in the posterior fossa or in the middle fossa.

Posterior fossa tumors, particularly tumors of the eighth nerve, may in their expansion cause irritation of the fifth nerve with trigeminal pain. Examination in such cases usually reveals the presence of other cranial nerve palsies which should make one suspicious of the underlying pathology.

Tumors of the Gasserian Ganglion have been described but in these cases the pain is almost constant in character; and some sensory disturbances can usually be found over the trigeminal area.

The treatment of trigeminal neuralgia may be either *alcohol injection* of the peripheral divisions of the trigeminal nerve; or *posterior root section*. Alcohol injection has its advantages and disadvantages.

The *advantages* of alcohol injection may be enumerated as follows:

1. It is a relatively simple procedure, and entails less risk.
2. It affords the patient immediate relief from an agonizing pain.
3. It can be performed in the office.
4. Alcohol injection permits a temporary demonstration of the *numbness* which must be substituted for the pain. This is of great importance because, in many cases despite careful explanation of this point to the patient, they may complain bitterly of the paraesthesia and numbness which follows section of the nerve, and when they know that it is permanent, they may say, having forgotten the severity of the previous pain, that they would rather have had the pain than the numbness. On the

other hand, if they get immediate relief from their agonizing pain, they will be more stoical in bearing the numbness; and when they are told that the relief is temporary and that with the return of sensation the pain is apt to return, they are usually prompt, upon recurrence of symptoms, to return for operation or re-injection, as they choose.

5. Another very important advantage of alcohol injection is that occasionally a case may prove to be somewhat doubtful, and the differential diagnosis between true and atypical trigeminal neuralgia may be difficult; and by injecting alcohol we know that, if the pain is relieved, the man is suffering from true trigeminal neuralgia. When the pain recurs, we can then confidently offer him *permanent relief by operation*.

6. Occasionally patients have suffered from intense attacks of trigeminal neuralgia over a period of weeks, during which they have taken practically nothing by mouth. It is wise in these cases, in view of their general debilitated condition, to attempt immediate relief by alcohol injection, cautioning them that, when the pain recurs, they must return sooner for operation.

7. Alcohol injection is indicated in those very few old patients whose physical condition is so poor that their life expectancy is not great. It should be mentioned that age itself is not a contra-indication to the operation. Trigeminal neuralgia is usually more common in the elderly, and experience has shown that this operation is tolerated very well, even by people in their eighth decade.

The *disadvantages* of alcohol injection are as follows:

1. The relief is temporary. The patient may be free of pain anywhere from six months to two years, with the average being closer to six months, and only the occasional case going two years.
2. Another is that after repeated alcohol injections, scarring occurs around the nerve and ganglion, and makes subsequent injection unsuccessful. When these patients submit to operation, the scarring increases the difficulty of the surgical procedure.

ALCOHOL INJECTION

It is very useful to have a skull available for reference. Usually a No. 20 three and a half-inch needle is used. The ordinary lumbar puncture needle is satisfactory, providing the bevel has been shortened considerably. The *short bevel* on the needle is of great importance because it is essential that, when a direct hit is obtained, the bore of the needle be within the sheath of the nerve, otherwise the alcohol may be injected *around* instead of *into* the sheath.

The *first landmark* is the lower border of the zygomatic process at about its middle. The *next landmark* is the condyle of the lower jaw. This can easily be felt by palpation back along the lower border of the zygomatic process, and having the patient open and close his mouth. The condyle is felt as it slides forward on the articular tubercle. Usually the point selected is about two or two and a half cm. in front of the tragus.

A small wheal is made in the skin with a fine needle. The long needle is then inserted slowly, novocaine being inserted ahead of it through the sigmoid fossa (the space between the condyle and coronoid process of the mandible), until it gently strikes the external surface of the external pterygoid plate, which is the *third landmark*. This usually occurs when the needle has penetrated between 30-40 mm.,—and it is wise to mark this off on the needle. If the needle penetrates deeper without striking the pterygoid plate, it should be withdrawn and aimed slightly forward and upward, for it is very easy to pass behind the process. From here, by means of short withdrawals and reinsertions, the needle is carried up to the base of the plate until the undersurface of the great wing of the sphenoid is felt.

To inject the third division, the needle is carried backward, being kept up in contact with the under surface of the sphenoid bone, and the base of the pterygoid. The foramen ovale is just above and behind the pterygoid plate; and just as the needle drops off the plate, the nerve is usually encountered as manifest by lancinating pain in the lower jaw. The needle should not go deeper than .05 cm. beyond the pterygoid plate for fear of injury to the eustachian tube, or the middle meningeal artery, or of entering the pharynx.

As the needle drops off the pterygoid plate, and the patient complains of pain in his lower jaw, the following procedure is of utmost importance. The needle is held steadily in place, and .05 cc. of two per cent novocaine deposited. Sensation is then carefully tested over the distribution of the third division; and unless anesthesia is secured, alcohol is not injected. If the novocaine is injected directly into the nerve, the patient will volunteer that his jaw is becoming numb. With a good anesthesia obtained, the alcohol is then injected. Eighty percent alcohol in one per cent novocaine has given satisfactory results. More than one cc. should never be injected. The alcohol may go back into the Gasserian ganglion and even into the cerebrospinal fluid.

To inject the second division, the needle, after hitting the pterygoid plate, is carried forward well up against the greater wing, until it drops off anterior to the pterygoid plate. Again the needle should not be inserted more than one-half to one cm. deep into the fossa. If the nerve is hit, the patient will have pain in the upper lip and teeth. The same process should be followed as outlined above for the third division, care being taken that good anesthesia be obtained with a small amount of novocaine before injecting the alcohol.

The injection of the second division is considerably more difficult than the third for two main reasons. The first is that, from the skin puncture, the needle tends to travel almost straight in for the third division; whereas the second division lies farther forward in the sphenomaxillary fossa, and may require considerable withdrawals and reinsertions of the needle before the front of the pterygoid plate is reached.

The second point is that the reflexion of the anterior edge of the pterygoid plate from the base of the sphenoid may present a distinct elevation that the point of the needle must surmount before it can drop into the fissure.

Supra-orbital Neuralgia.—When the neuralgia is limited to the *supra-orbital nerve*, alcohol injection at the supra-orbital notch may offer prompt relief. However, injection is not always satisfactory owing to the fact that there are many small branches which cannot be injected directly. For these cases, simple *supra-*

orbital neurectomy is advisable. This is a relatively simple procedure involving a very short hospitalization and many times gives relief for two to five years. Furthermore, they are spared for a considerable time the corneal anesthesia which must ensue when the fibres going to the first division are sectioned in the posterior root.

SURGICAL TREATMENT

The surgical treatment of trigeminal neuralgia consists of the section of the fibres of the posterior root. Sectioning these fibres before they reach the ganglion prevents regeneration, and therefore the relief is *permanent*. The almost universal procedure is the subtemporal approach as devised by Frasier. This is usually done in the upright position. It can be done under local anesthesia.

A seven-cm. incision is made extending diagonally upward from a point two cm. in front of the tragus at the upper border of the zygoma, and extending upward and slightly backward. The incision is carried down to the temporal bone. While the skin, sub-cutaneous tissue and muscle are held retracted, an opening is made in the temporal bone with a burr, and enlarged with rongeurs until a defect approximately four cm. in diameter is obtained.

The dura is then elevated from the base of the middle fossa, and the middle meningeal artery followed down to the foramen spinosum, which is plugged with wax impregnated cotton. The middle meningeal is then cut, and just anterior and mesial to it the third division of the trigeminal is identified. This is followed backward to the ganglion, care being exercised to carefully separate the temporal dura from the dura propria of the ganglion. Just posterior to the ganglion, the fine sensory roots are visible through the thin dura propria.

The dura is then opened by a horizontal incision, and the sensory roots can then be cut. If the pain involves all three divisions, the entire sensory root is sectioned. The motor root is always spared, and is easily identified as a small bundle lying mesially to the sensory root, and having an obliquely downward course. If the pain does not involve the first division, the ophthalmic fibres are spared, thus permitting the retention of the corneal sensitivity. The

ophthalmic fibres are usually differentiated from the second and third division by the slightly upward course they follow as they approach the ganglion.

With the sectioning of the fibres, all bleeding is carefully controlled and closure is effected. The patient is usually able to sit up in bed on the third day, and the average patient is discharged on the sixth or seventh day.

Dandy prefers the *sub-occipital approach*. In this procedure, a small sub-occipital unilateral craniotomy is performed, the dura opened widely, and the cisterna magna emptied, giving better exposure. The cerebellar hemisphere is retracted mesially and downward, and the trigeminal root exposed as it leaves the pons.

Care must be exercised not to traumatize the seventh nerve, which lies as a thin filament in the path of the exposure. The petrosal vein lies directly posterior to the fifth nerve, and thus must be taken care of by the surgeon before he can section the nerve itself. It can usually be controlled by cauterization. The motor root is easily differentiated so that differential section of the root is possible. The results, in Dandy's hands, have been as gratifying as the sub-temporal approach by other neurosurgeons. However, this operation is an intradural one, and fraught with considerable more surgical difficulty than the sub-temporal approach. Most neurosurgeons prefer Frasier's trans-temporal approach.

Post-operative complications are comparatively rare. If the sensory root of the first division has been cut, the patient must be cautioned about the insensitivity of the cornea. He must never rub his eye. Boric irrigations of the eye must become part of his daily toilet. It is wise to keep the eye closed for five to seven days after the operation; and thereafter the patient should be instructed to wear glasses with a protective side shield to prevent dust from entering the eye. If corneal ulcerations occur, it may be necessary to suture the lids temporarily.

Herpetic ulcerations around the lips and tongue almost always follow the operation. They usually occur on about the second or third day, and disappear on the sixth or seventh day.

Facial paralysis occurs in a small percentage of cases post-operatively. This paralysis may come on immediately following operation, or may occur within two or three days. It is generally due to traction on the great superficial petrosal nerve, with resulting edema or hemorrhage within the facial canal. Fortunately the facial paralysis always disappears, although complete recovery may be delayed for many weeks or even months. This complication is less frequent when the operation is performed through the posterior approach.

Complete anesthesia for all forms of sensation except deep pressure is an unavoidable sequela. Fortunately in the large majority of cases the numbness is forgotten, and the trigeminal neuralgia cases are usually the most grateful group of patients that the neurosurgeon has.

PROGNOSTS

In skilled hands, the mortality is now less than one per cent, despite the advanced age of the majority of the patients, and the frequent presence of high blood pressure, arteriosclerosis, and cardiac and renal disease.

Following operation, relief from trigeminal neuralgia is complete and permanent on the side operated upon. Preservation of the ophthalmic fibre prevents corneal complications, but leaves the possibility of a recurrence of pain in this region. There is no functional disability of any consequence. Food may collect on the anesthetized side of the mouth, but patients soon accustom themselves to this, and subconsciously run their tongues over the anesthetized area to clean out retained particles.

GLOSSOPHARYNGEAL NEURALGIA

Glossopharyngeal neuralgia is another disease of unknown etiology, characterized by recurring paroxysms of excruciating, knife-like pain located in the sensory distribution of the glossopharyngeal nerve. It was first described as such by Wilfred Harris in 1921. Previous to that, neuralgias which were probably of this type were described but not recognized as such. Harris had treated two cases for ten years without appreciating the true character of the paroxysmal pain until he saw a patient with

an epithelioma of the tonsil who had a similar pain. It then dawned upon Harris that the two patients with the unexplained paroxysmal pain starting in the throat, tonsil, and anterior pillar of the tonsillar fossa, and radiating to the ear and upper part of the neck, was identical in type with that of true trigeminal neuralgia. Since that time many more cases have been described; and while it is not as common as trigeminal neuralgia, it is by no means a rare disease.

The symptoms consist of attack of pain similar in all respects to the pain in trigeminal neuralgia, except that it involves the distribution of the glossopharyngeal nerve. The tonsil or posterior pharynx frequently constitutes a trigger zone, so that any form of swallowing usually precipitates an attack.

The attacks consist of lancinating pain involving the tonsils, the fauces, posterior pharynx, and radiating to the ear. During an attack, many of the patients force a finger into the external auditory canal, some getting some relief from this maneuver. Unfortunately the attacks are precipitated by the unavoidable act of swallowing; and consequently, in a severe case of glossopharyngeal neuralgia, the patient is in a pitiable state.

To Adson goes the credit of suggesting the form of treatment now in common use for this condition, and that is the *intracranial section of the glossopharyngeal nerve* by means of a unilateral suboccipital craniotomy. He suggested this after having had the experience of performing a peripheral avulsion of the glossopharyngeal nerve with complete relief of all pain; and then having the pain recur some period after the operation, just as it does in trigeminal neuralgia when the nerve is cut distal to the ganglion.

Operation.—The operation consists of making a unilateral suboccipital craniotomy exposure. By emptying the cisterna magna, considerable room is obtained for retraction of the cerebellar hemisphere. The cerebellum is then retracted mesially, exposing the seventh and eighth nerves making their exit through the internal auditory meatus. Just mesial and posterior to this is the *jugular foramen*, through which the ninth, tenth, and eleventh nerves

make their exit from the cranial cavity. The ninth nerve is easily recognized as such, being most anteriorly placed of the three, and smaller in diameter. It is easily drawn aside with a nerve hook and divided.

The operation is one of the simplest of intracranial procedures, is practically devoid of danger, and leaves no sequelae that are noticeable to the patient. Taste is lost over the posterior third of the tongue on the affected side, but the anterior two-thirds are not affected. Patients observe that hot or cold liquids are not appreciated on the side of the divided nerve, and that this side of the pharynx is not sore during pharyngitis. Sensation is lost along the pharyngeal wall from the vault to the recessus piriformus. The gag reflex is lost. The patient has no difficulty in swallowing.

MENIERE'S DISEASE

Meniere's disease is probably a tic of the eighth cranial nerve, just as trigeminal neuralgia is a tic of the fifth, and glossopharyngeal a tic of the ninth. In its typical form, it is characterized by sudden paroxysmal attacks of severe vertigo, nausea, and vomiting, and a unilateral tinnitus, which is referred to an ear which is subtotally deaf. There is no recognized cause of this disease, nor is there any accepted pathology or pathological physiology.

The attacks come on suddenly without warning. Between seizures the patient may be quite well except for persistent deafness, and more or less constant unilateral tinnitus. The attacks may be so sudden that the patient may be thrown to the floor. Objects seem to whirl about constantly in either direction. The tinnitus becomes more marked just before, during, and after an attack. Nausea and vomiting are usually associated with the attack, but in some cases they may be lacking.

The most constant symptoms in Meniere's disease are the partial deafness, the unilateral tinnitus on the same side as the deafness, and the paroxysmal attacks of vertigo.

The attacks may last several minutes, several hours, or sometimes may persist for days. Weeks or months may intervene between attacks, but occasionally they may recur so rapidly that for weeks the patient may not be free

of any of his symptoms. Vestibular function, as shown by caloric tests, may or may not be impaired.

True Meniere's syndrome must be distinguished from labyrinthitis, cerebello-pontine angle tumors, and occasionally from a chronic cysternal arachnoiditis. The differentiation is made largely on a basis of a careful history of attacks, evidence of any labyrinthitis or middle ear infection, or the presence or absence of other signs accompanying angle tumors, such as cerebellar dysfunction, choked disc, and adjacent cranial nerve palsies.

The treatment of Meniere's disease may be either conservative, or radical. Furstenberg in 1934 advocated a *sodium-free* diet, together with large amounts of *ammonium chloride*. In many cases the patients have been helped considerably by this regime. However, the diet is a very stringent one, and some patients are unable to follow it.

In other cases even strict adherence to the diet and administration of ammonium chloride has no effect on the attacks. In these latter cases *section of the eighth nerve* is indicated. This was first described by Dandy in 1928 for this condition. At that time he had sectioned the eighth nerves of nine cases of Meniere's disease with complete relief of the attacks of vertigo and nausea and vomiting. However, the tinnitus usually persists, although it is markedly diminished, and usually is not distressing.

The operation is performed through the same unilateral suboccipital exposure as is used in sectioning the ninth nerve in glossopharyngeal neuralgia. The process may easily be performed under local anesthesia. There is no pain when the nerve is divided. Extreme caution, however, must be observed in sectioning this nerve, because in approaching it from a postero-lateral direction, the seventh nerve lies directly beneath it, and care must be exercised in elevating the eighth nerve from the seventh, and definitely differentiating the latter before section of the eighth nerve is attempted.

More recently an additional refinement to this procedure has been added in sectioning only the vestibular portion of the eighth nerve

when the patient still retains serviceable hearing on that side, and thus avoiding permanent deafness in that ear.

Of the three nerve sections, this is probably the easiest one. It is more easily identified and easier to approach. The attacks do not recur after operation. If the vestibular tests had shown loss of function previous to operation,

there is usually no after-effect. However, if the vestibular function had been normal, the patient may have for a period after operation varying degrees of dizziness on suddenly turning the head. This gradually abates and disappears after a few weeks or months, and probably is due to the readjustment of the sense of equilibrium.

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PERINEAL REPAIR,—CHOICE OF OPERATION

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Any relaxation of the posterior vaginal wall which will respond adequately to denudation, followed by approximation of the separated or elongated pubic portions of the levatores ani, requires no discussion before this audience of specialists. The protracted controversies of a previous generation, regarding the values of the various geometrical patterns excised from the vaginal covering of a low rectocele, cause no thrill in any modern group of gynecologic surgeons. One's interest centers chiefly on whether the above-mentioned muscles are efficiently approximated, and on whether this simple type of operation is adequate to correct the deformity. Reinforcement by approximation of the superficial muscles and fascia seems to aid in giving adequate support, while still leaving a vaginal orifice adequate for the patient's marital duties.

This does not mean that simple perineorrhaphy should be done carelessly, as the fact that the perineum has been carefully and adequately built up, has often been the saving grace in operations for multiple pelvic lacerations. A good perineal repair has saved many a poor operation for prolapsus, at least symptomatically.

B. P. Watson¹ employs a refinement of the basic procedure, by dissecting up the posterior vaginal flap at three different points, leaving between these three separate channels, two columns of fascial tissue between the vaginal and rectal walls, in the long axis of their cavities. These columns of "fascia propria of the rectum", to quote, are then united over the rectal wall beneath the levatores, which are then approximated as usual. The fascia may be overlapped, or sewn edge to edge, and forms a very efficient and resistant reinforcement in the repair of rectocele. It can also be relied upon to take care of the next more serious lesion, the "high rectocele", with considerable efficiency. My experience with this procedure of B. P. Watson is limited to protrusions involving only one-half the distance from fourchette to cervix, but I have seen Watson employ it for lesions extending even higher up.

Many authors² contend that this term "high rectocele" is a misnomer, and that these cases which show relaxation of the posterior vaginal wall up to the region of the cervix are, in reality, rectocele below and enterocele above.

For this lesion, "high rectocele", many of us have found very pleasant results from a dupli-

cate of the procedure commonly employed to repair the average cystocele; i. e., incising the mucous membrane in the middle-line from the fourchette to within one or two cm. of the cervix, and dissecting the vaginal flaps off to either side, leaving the underlying fascia attached to the rectal wall if possible. This can usually be accomplished by using sharp dissection to start the flap, and keeping this flap thin before gauze dissection is used. Seldom do we obtain as adequate a layer of fascia as over the cystocele; but a thinner, more imperfect one will, as a rule, give adequate support at this higher level. Watkins³ taught that the fetal head, in its destructive course, spread this fascial layer out so thin that merely scattered islands of pre-rectal fascia remained, and he picked up these islands in purse-string stitches. However, if the material is at all adequate, we find mattress sutures from side to side usually are easier. These mattress sutures frequently are also of value in stopping the venous oozing from the depths of our dissection.

When the fascia remains mostly on the mucous membrane flaps, it can be raised as a separate sheet, if it is peeled off the mucous membrane flap with a scissors starting from below upward. It is best to start this dissection at a point midway between the attached and the severed edges of each vaginal flap. Overlapping this fascia in the mid-line is simple and efficient, and the mucous membrane can be closed over it after all redundancy has been cut away.

A true enterocele seems best treated as a hernia with ligation and amputation of its sac, after which it can be reinforced by approximating the utero-sacral ligaments below it, before the above procedures are carried out.

Where cystocele exists, the mid-line incision is best employed in such a way that the mucous membrane flaps are kept thin, leaving all available fascia adhering to the bladder wall. Mattress or continuous locking sutures to in-fold this fascia from side to side, will have a valuable result, not only in obliterating the cystocele, but also in elevating the uterus to a higher position if needed and pushing the cervix backward and upward, to allow the fun-

dus to assume its normal position. Excess mucosa can then be cut away, and closed by interrupted or continuous locked sutures. In using a continuous suture on these tissues, especially in the anterior vaginal wall, either deep or superficial, care must be exercised to prevent too much shortening in the length of the suture line. The reason is that too great a shortening will not allow the cervix to stay posterior, but will actually pull it forward, and in exaggerated cases cause a protrusion of the cervix at the introitus.

One important point in avoiding injury to the bladder wall, in all repair procedures of cystocele, as Studdiford⁴ points out, is to gain a line of cleavage which leaves the fascial layer intact over the bladder surface. One easy way to do this is to separate the vaginal mucous membrane from the underlying structures by sharp dissection, which is easily accomplished by snipping with the points of the curved scissors held nearly perpendicular to the flap as it is separated. Another method is to start the separation by sharp dissection with the scalpel, cutting against the undersurface of the mucous membrane layer, as it is stretched over the fingertips of the left hand, by traction on Kocher clamps attached to the edge at intervals of approximately three cm. apart.

On several occasions recently, our younger operators on the service at Bellevue Hospital have had the misfortune to tear holes in the bladder in the course of their exposure of the cystocele. We feel that this is due to using a line of cleavage between the pubo-cervical fascia and the actual bladder sub-mucosa, thus putting a great deal of strain on the very easily friable mucosa. Repair immediately has in each case been followed by firm healing and no complications have arisen.

The upper limits of the incision for cystocele repair must be extended upward to repair a urethrocele, or partial incontinence due to relaxation.

As the urethra is dragged down from its normal attachments under the pubic arch in a developing urethrocele, it rotates forward and downward on the symphysis as an axis.⁵ This results in its being directed more upward, as is the meatus, and the principle of the Kelly,

the William T. Kennedy, and other successful procedures is to support the loose floor of the urethra by mattress sutures inserted at either side and tied beneath it. This reinforces the supporting muscle and fascia which has been weakened.

For cases of occasional incontinence with severe cough or sneeze, with little displacement of the urethra from its normal bed, two or three Kelly stitches suffice. In cases of marked relaxation of the urethra with leakage on walking about, or severe wetting with a cough, preference should be given to the William T. Kennedy operation. His deeper dissection, to free adhesions to the lateral adjacent tissues, gives a better opportunity for more thorough reconstruction of the urethral supports. Whether the urethral wall itself should be constricted by mattress sutures in its own surrounding fascia can be judged by the degree of gaping of the urethral canal. The use of silk sutures in this operation is being abandoned, even by Kennedy.⁶ We have had five urethral fistulae develop at Bellevue at intervals of from two weeks to three months post-operative, suggesting to us that the leaks were due to cutting through of the silk rather than direct injury to the mucosa at the time of operation.⁶

In all degrees of prolapsus uteri, shortening of the relaxed broad ligaments is required to restore the uterus to its normal level in the pelvis.⁷ In cases of first and second degree,—i. e., where no more than half the entire uterine body protrudes from the vulva,—the principle of the Manchester type of operation is very useful. In every prolapsus the cervix swings forward as it swings downward; and by plicating the broad ligaments in front of the cervix, it not only shortens them enough to take up the slack which has permitted the uterus to sag, but also pushes the cervix backward to give the uterus its normal anteversion. Very early cases with minimal prolapsus can usually be controlled by repair of the cystocele and rectocele, and shortening the round and uterosacral ligaments intraabdominally. Any more advanced case needs broad ligament shortening.

Though the German and English schools

are credited with the idea as early as 1888, it was not until 1906 that adequate broad ligament reefing was brought out in this country practically simultaneously by Budley⁸ and Hertzler, the latter being known today as the "Horse and Buggy Doctor". They cut a portion loose in the lower part of the broad ligaments, and overlapped it in front of the cervix with very satisfactory results.

The foregoing procedures do not preclude subsequent child bearing.

Many of the more advanced cases of cystocele with incontinence, rectocele, and prolapsus occur after the fertile period so that the following procedures enter our field of choice.

In an elderly patient with a large, thin-walled cystocele as the principal lesion, Watkins' interposition operation is very valuable, even in the presence of mild incontinence. If the urinary leakage is severe, it is wiser to place some sutures to support the badly relaxed urethra before interposing the fundus uteri. Many experienced operators condemn the interposition operation off-hand, probably because they have tried it on cases where the broad ligaments were relaxed; and the end result has been a protrusion of the entire organ. In such cases the broad ligaments must be shortened to keep the cervix from swinging forward and outward on the suspended fundus as an axis.

A simple method in mild cases is to cut a large, wide wedge out of the anterior cervical lip so that approximation from side to side gives the necessary reefing of the relaxed broad ligaments. For more marked cases, the Manchester or Dudley type of reefing fills the bill.

Amputation of an elongated cervix adds to the ease of completion, and aids in a better result in both these procedures.

With these operations at our command, the field of ventral fixation of the uterus, or its stump, intraabdominally, seems to have a smaller and smaller field.

In the third degree,—i. e., complete prolapsus in the child-bearing age,—the Manchester operation with adequate cystocele and rectocele repair can of course be assisted by intraabdominal shortening of the round and uterosacral ligaments, but usually this last procedure

has little merit due to the attenuation of the latter tissue.

For the non-childbearing case of third degree prolapsus, the Mayo type of vaginal hysterectomy is a highly valuable procedure,⁹ where the patient will stand the strain of operation, because it permits such extensive shortening of the extremely relaxed broad ligaments.

Many times it is necessary not only to interpose the broad ligaments under the bladder, but also to do a repair of the cystocele or urethrocele and a high perineorrhaphy. This combined operation requires from one to two hours in average hands, so that we must resort to make-shifts in the elderly case.

I am sure everyone here is familiar with the clamp method of vaginal hysterectomy. This operation has been carried on from an earlier generation to the present principally by the devotion of James W. Kennedy to the memory of his old chief, Joseph Price. Operating before the senior gynecologic organization of this country, he is said to have completed the procedure in one and one-half minutes. A tyro can accomplish it in ten minutes, and, where the risk is bad, cystocele and rectocele repair can be left to a later date, and then often done under local anesthesia. We have done thirty-two clamp hysterectomies at Bellevue in the past five years, with one death from cerebral hemorrhage in a patient aged seventy-eight years; and one from embolism fifteen days post-operative.

Many of these patients have been such awful wrecks physically that we have wondered

whether they would survive the rest in bed necessary to heal up their vaginal and cervical ulcerations.

For those of more conservative tendencies, I can recommend the Le Forte with Neugebauer modification.⁹

This can be done with a mild sedative and no local or general anesthesia. I have done one on nembutal gr. i by mouth and a number with morphine gr. one-sixth and scopolamine gr. one two-hundredth by hypo. My oldest case is eighty-one, and my youngest sixty-four years of age. The highest blood pressure was 240 over 160, aged seventy-eight. They can be gotten up after three days, and usually can be home in a week, if forty-day chromicized catgut is employed. In our experience, one in ten has recurred, but they can be repeated very easily as the patient has little discomfort. A high, tight perineum adds greatly to their security, and approximating the levators is the only uncomfortable part of the procedure.

We must remember that the use of local anesthesia has widened the field of usefulness of all these major plastic procedures, even including vaginal hysterectomy, and the Watkins interposition, so that fewer and fewer cases fall in the clamp and Le Forte groups.

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THE MANAGEMENT OF THE RHEUMATIC PATIENT

By **JEROME G. KAUFMAN, M.D.**, Newark, N. J.

Read before the Section on General Medicine of the Annual Meeting of The Medical Society of New Jersey, May 19, 1938.

Although I am neither bringing you a new message, nor calling to your attention spectacular departures from the usual rheumatic disease therapy, I wish to take this opportunity to point out the most salient features of the modern handling of this all too prevalent disease. It is indeed sad to contemplate the fact that rheumatic heart disease has an inexorable predilection for the young; and if we are to make any headway at all in the prevention of serious crippling and the burdening of society with future cardiac invalids, we must not overlook even the simplest minutiae in rheumatic heart disease therapy and management. Therefore, please forgive any features of my paper which at times may seem to you rather elementary.

We gather our little patients from the poorer homes or families of the so-called lower economic brackets. Rheumatic heart disease is essentially a disease of the slums, not Park Avenue, though occasionally we do find a case here and there in such places as Narragansett Pier and Rumson Road. With this in mind, you will understand from what sources we draw our little rheumatics into the Cardiac School, which is called the Theresa Grotta Residential School for Cardiac Children, and is located at Caldwell, New Jersey.

It was immediately apparent to us, when the school was opened, that the management of these cases involved a much wider scope than the mere treatment of the patient alone. This meant the planning of a strict regime for the child, and an attempt to change the home environmental factors, which were believed to be important in the exacerbation of this disease. The admission of patients was limited to those coming under the groups designated as Class I or II in the American Heart Association classification, with which I am sure you are familiar. These children were received from hospitals in the community where they had been bed patients for some time, and were definite cases of organic rheumatic heart disease.

The staff of the institution consists of pediatricians, a cardiologist, psychiatrist, dentist, and a list of consultants whose services are utilized whenever necessary. In addition to the medical staff, there are graduate nurses, laboratory technicians, a teacher, social workers and volunteer workers.

When a child is admitted to the institution, he is isolated in bed for a period of one week. During this preliminary period the pulse, temperature, and respiration rates are carefully charted three times a day. A thorough physical examination and routine laboratory studies are made. If the pulse and temperature rates are below 100 during the week, and if the laboratory data are essentially negative, the child is then permitted to be up during the day with the exception of a two or three-hour rest period in the afternoon. In addition to the temperature, pulse, and respiration rates, the laboratory procedures which we are using are:

1. The erythrocyte sedimentation rate.
2. Complete blood count with special emphasis on the differential count.
3. The Tillett-Garner fibrinolysis test.
4. Urinalysis.
5. X-ray studies.
6. Electrocardiography.

I will now discuss the value of each of these in detail.

1. SEDIMENTATION RATE

The erythrocyte sedimentation rate: The technic employed is a modification of the Westergren method using 0.5 cc. of 3.7 per cent sodium citrate, and 2 cc. of blood. The normal rate of sedimentation by this method is less than 10 mm. in the first hour. This, in the last analysis, seems to be the most reliable test, for the sedimentation rate is definitely and regularly increased in rheumatic carditis, and is both a guide and check in following the activity of the disease.

An important exception to the above statement is congestive heart failure. Here, although

the sedimentation rate may be decreased, activity may be present. This is explained upon the basis of increased carbon dioxide content of blood in heart failure. As the patient becomes compensated, the sedimentation rate frequently rises. The increased rates in rheumatic fever are said to be due to increased plasma fibrinogen and globulin.

2. THE BLOOD COUNT

There are two phases of this count which are important. The first is a determination of the hemoglobin and red blood cell count as an index of anemia. The colorimetric method of hemoglobin estimation is to be preferred at all times.

The second phase is the number of polymorphonuclear cells and immature cells as a guide to the presence of activity. The increased percentage of immature cells in activity, the so-called "Shift to the left" of Schilling, has not been as consistent nor as reliable as the erythrocyte sedimentation rate in our experience. There is a decrease of eosinophiles during the acute carditis with a return to normal in the convalescent period.

3. THE TILLET-GARNER TEST

The Tillett-Garner¹ test, which was reported in 1933, depends on the fact that hemolytic streptococci have the capacity to liquify rapidly the clotted fibrin of normal human plasma. This fibrinolytic action is due to an enzyme, a specific product of the streptococcus. A large percentage of cases of rheumatic heart disease has been found to contain in the blood an anti-fibrinolytic substance, probably anti-body in nature, which inhibits this fibrinolysis. This test has not been used sufficiently to determine its exact value.

4. URINALYSIS

Urinalysis is routine, with special emphasis being placed on the presence of gross or microscopic blood, since hematuria is a frequent finding in rheumatic heart disease. The complication of acute glomerulo-nephritis in rheumatic fever is rare. Fishberg² in his well-known text book on "Hypertension and Nephritis" reports seeing only an occasional case.

5. X-RAY STUDIES

Radiographic studies are made just prior to admission, and at six months' intervals thereafter. These include fluoroscopy, orthodiagnosis, and teleoroentgenography. The teleoroentgenogram in mitral disease shows at first an accentuation of the left auricle, which enlarges in its posterior aspect and to the right, so that there is an encroachment upon the esophagus which may be narrowed and constricted, particularly well observed in the oblique view where the retrocardiac space is seen to be diminished. The left auricle may finally be seen as part of the right border of the heart. The right auricle may also be enlarged, especially in stenosis. The left ventricle is enlarged only in those cases where regurgitation predominates. The aortic knob appears receded due to straightening of the left auriculo-pulmonic curve, which is due to pushing up of the conus of the right ventricle and enlargement of the pulmonary artery.

In the combined lesion, namely mitral and aortic disease, the left ventricle becomes enlarged. The apex tends to point downwards, the long axis of the ventricle becoming oblique rather than horizontal. There is enlargement to the right also. This picture simulates the aortic silhouette.

6. ELECTROCARDIOGRAPHY

In our series, right axial rotation, occasionally high, broad-notched P waves, and rarely an increased P-R interval, representing a delay in the transmission of the stimulus from the sino-auricular node to the auriculo-ventricular node, have been noted. We have seen only four instances of auricular fibrillation. This arrhythmia is rare before puberty, in marked contrast to its frequent occurrence in adults. Occasionally a premature beat interrupting an otherwise regular sinus rhythm is recorded.

Electrocardiograph check-ups are made at frequent intervals in the active cases and about once a month in the inactive ones.

MEDICAL TREATMENT

The medical treatment in the convalescent stage is of minor importance, and consists of simple handling of the symptoms as they arise.

Salicylates, still the mainstay, are used in appropriate doses when indicated for their antipyretic and analgesic effect. Digitalis is used in the decompensated cases, as is well known. Children tolerate digitalis in rather large doses, and the drug is effectual. We have used only the powdered leaf preparation, which we find very satisfactory. Our children are also given cod-liver oil during the winter months and vitamin C (cevitamic acid) has recently been introduced, following the brilliant work of Rinehart³ and his co-workers. Iron in large doses, 45 to 60 grains daily, has been used with very little success in the treatment of the accompanying anemia. Iron does not seem to work well in the presence of infection.

It would be pertinent at this time to begin the discussion of the management of those children who do not have normal charts and whose temperature or pulse rates are decidedly elevated. Such patients are strictly confined to bed. Their meals are brought to them, and if they are well enough to participate in their studies, the teacher, who has only fifteen pupils and is therefore not overburdened with work, teaches them at the bedside. The child remains so confined until he has a normal pulse rate and temperature for at least a two weeks' period, and what is more important, a sedimentation rate which is approaching normal. The length of time required to produce this type of chart is uncertain, and may be weeks, months, or years. It is difficult to prognosticate the length of time that a child will have to remain in bed. This is indeed a complex problem, but the greatest majority of such children will eventually, after about three to six months, become inactive. Only then will they be permitted to get up gradually; at first perhaps for one or two meals and later for an hour or two daily. This period is gradually increased weekly until the child is on a normal program, which means that he is up for the full day, except for a two or three-hour rest period in the afternoon. Occasionally in instances where a child has been in bed about a year and seems to be at a standstill, with a pulse rate of 100 or more and with normal temperature, it becomes advisable to allow him to get out of bed. This is done with due cau-

tion and only after careful consultation with the entire medical staff. It is surprising, however, that such a case will do well in spite of such a set-back.

I am sure that you will be interested in learning that we do not place any physical restriction on a child who is out of bed and on a full program. The child is permitted normal activity, including skating, playing of games, etc. We have seen no injurious effects from this, and we have learned that when these children are tired, they will go indoors and rest, voluntarily. The average stay at the school is about fourteen months. In rare instances, a child remains for a much longer period.

We have not been sufficiently impressed with the supposed value of the newer therapeutic methods such as vaccine, roentgen, and heat therapy to yield to these indiscriminately. The uselessness of vaccines has been masterfully brought out by Stroud,⁴ of Philadelphia. In this connection, may I say that there is no place for therapeutic pyrotechnics in the treatment of rheumatic heart disease. Treatment to be of value in any case must be absolutely coordinated with the underlying pathology of the disease, and this is a good rule to follow in the practice of medicine in general.

THE SOCIAL WORKER

While we are observing the child in the school, rehabilitating him, a social worker visits the home periodically and strives to prepare the home for his return. You are all aware of the relationship of environmental factors to this disease. It cannot be stressed too forcibly that this social work must be delegated only to competent and well-trained workers, since the benefits accrued at the school may be dissipated all too rapidly at home. We all know of many such instances.

The social worker carefully instructs the mother and older members of the family as to the proper diet for the child, the number of hours of rest, exercise, etc. She also instructs the mother how to detect certain suspicious signs of reactivation of the disease. Instructions are given as to when the child should report to the follow-up clinic, and the social worker is held responsible for this follow-up.

One of the difficult problems that must be overcome at the outset is the needless pampering and petting which the child is likely to be subjected to at home. Indeed this is the very place where kindness can kill. We have seen children who were so guarded, so shielded, that they were not permitted to walk, being carried about by members of the family.

The social worker often discovers that other members of the family have heart disease. The frequent occurrence of more than one instance of rheumatic heart disease in a family is well known. This was ably described by Coombs,⁵ Levine,⁶ and Paul.⁷ There are two sisters in our group whose entire family is so afflicted, the father and mother having died from cardiac failure a few years ago. May Wilson⁸ stressed the importance of heredity as a contributing factor. This opinion is still rather controversial.

THE PSYCHIATRIST

Coöperating with the social worker is a psychiatrist who plays an important part in the group. He studies the relationship of the child to his family, to the other pupils in his class, to his playmates and environment in general. Various behavioristic tendencies of the child,—for example, attention getting,—are pointed out by the psychiatrist, for which he recommends the necessary therapy. The mental age of the child and ability to carry out his program are also determined by this member of the group.

During the past eight years, eighty-eight children were admitted to the school; of these thirteen died. The age of admission ranges from six to twelve years, the oldest members of the entire group now being nineteen years old. We have had to re-admit fourteen children who had been previously discharged. These children were re-admitted because of a recrudescence of the disease.

RESPIRATORY INFECTION

I must not fail to emphasize one very important point; that is, the relationship of upper respiratory infection to the reactivation of cases of rheumatic heart disease. Although this was so ably presented by Haig-Brown⁹ as

early as 1886, it was not until but a few years ago, following the work of Coburn,¹⁰ that much attention was paid to this relationship. It is the belief of many workers, and one which was brought out in our work as well, that about thirteen days following an upper respiratory infection after a latent period, rheumatic hearts may reactivate. With this thought in mind, we have insisted on two or three weeks of complete bed rest for each child developing such an infection. During this time, careful laboratory studies are made. The importance of this point cannot be overestimated, for many hearts are needlessly strained and even permanently damaged through the negligence of the above regime.

MORTALITY

The mortality of rheumatic heart disease has been reported by many observers. Among them DeGraff and Lingg¹¹ studied a series of 1,633 cases between the years 1921 and 1931. They were able to follow three-fourths of their cases, in which series there was a mortality of 39.4 per cent, and the mean duration of life of their patients was fifteen years. To reiterate, of every 100 cases of heart disease observed for a period of ten years, only sixty were alive at the end of that period.

Bland and Jones¹² in a recent article reviewed the fatal course of 306 patients who died of rheumatic carditis. Almost one-half of these patients died within the first three years, and 62 per cent of the patients died within the first five years after the onset of the disease. It is well established that the first years are the most critical ones, so that if a child passes through puberty and is free of reactivity for a period of over five years, the prognosis is definitely favored.

CONCLUSION

After a period of eight years of concerted effort at the cardiac school, coming in daily contact with a sizeable group of rheumatic children in all stages of the disease, we arrive at the inevitable conclusion that the convalescent school occupies a singularly important place in the management of cardiac children. It should serve as a liaison institution between

the hospital, limited to active cases, and the home where a normal routine is enforced without regard to the limitations of a sick individual. The creation of many such institutions throughout the country would be indeed an important step forward in the combatting of a disease whose etiology is still unknown, with therapeutic methods which still leave much to be desired; but, on the other hand, with a

future fraught with marvelous possibilities for systematic research.

Before closing, one more point must be mentioned—*prophylaxis*. This, although an ideal and accepted procedure in diseases where the cause is definitely known, cannot be discussed dogmatically in considering rheumatic fever. That, unfortunately, must remain for a more enlightened future.

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THE TOXEMIAS OF PREGNANCY

By ARTHUR J. WALSCHEID, M.D., Union City, N. J.

Read before the North Hudson Hospital Clinical Society, February 8, 1938, under the auspices of the Maternal Welfare Committee of the Hudson County Medical Society.

Pregnancy changes in the female organism have a double purpose,—first, to guarantee foetal development; second, to foster prenatal preparation for labor and delivery. A healthy organism can usually carry these changes on with a minimum of discomfort to the woman, and can meet its new problem with a complete response by making economic utilization of metabolized products to promote fetal growth, and by preparing the birth canal through softening and boggying of tissues for easy dilatation. On the contrary, in women constitutionally below par, or with preconceptively disturbed systemic and organic functions, the female organism does not as a rule respond favorably to tissue and organic alteration. Such women, indubitably, are likely to be the victims of the toxemias of pregnancy.

Intra-uterine implantation, development of the placenta, and growth of the foetus regularly induce retroactive effects in the mother.

The production of albuminoid bodies, neutral fat, hemoglobin molecules, all nutritious material for foetal maintenance from the maternal blood is carried on through vital activity of the foetal cells in the placenta, without regard to the nutritional condition of the mother herself. This interchange is usually successfully regulated, but cases not infrequently arise where there is lack of nutritional regulation due to a physiologic pathology in the mother or disturbance of the vital activity of the foetal cells in the placenta. Both the ovarian hormone, active in early pregnancy, and the placental hormone, developed later in the pregnancy, have an activating effect upon the other glands of internal secretion. The thyroid, the parathyroid, and the pituitary glands are stimulated beyond their normal levels, and their interrelationship is altered, with a resulting increase in general metabolism and an oversensitization of the vegetative nervous system.

Although no specific toxins of pregnancy have ever been isolated, unquestionably toxic substances get into the circulation—

First, partly from disturbances of the albumin metabolism;

Second, partly from the breaking down of the maternal tissue;

Third, from the placental metabolism;

Fourth, from the fact that the organism produces an enzyme which acts against the released chorionic elements from the placenta. Various enzymes also reach the maternal organism from the placenta itself.

Fifth, there is an effect produced by the foetal hormones which are conveyed through the separating placental wall. Increase in the breaking up of the red blood cells is carried on in the placenta. The overflowing of the maternal organism by all these substances throws a tremendously increased load of work on the kidney, liver, heart and lungs, so that they may be unable to maintain their normal metabolic rhythm, with the result that an allergic condition develops in the pregnant woman. This is incipient toxemia.

TYPES OF TOXICOSIS

The various types of toxicosis are dependent upon the individual constitution of the woman, so that they cannot be regarded as having an identical etiology. They depend upon three factors:

1. The demands made by the ovum or fetus upon the maternal organism.
2. The physiologic and pathologic idiosyncrasies of the woman.
3. The effect of exogenous factors.

During the first months of pregnancy, the first trimester, constitutional disturbances arise from the stomach, intestines; and vasomotor system through enervation of the vegetative nervous system. During the second trimester, the organic and functional responses of the body seem usually to have adapted themselves to their new problem. During the last trimester, in the terminal period, there is danger that the products of metabolic disturbance may overwhelm the system with damage to liver and kidneys, followed by the appearance of

pathologic oedema with frequent termination in convulsions and coma.

CLASSIFICATION OF TOXEMIAS

Pregnancy toxemias may be classified under the following heads:

1. Emesis and hyperemesis;
2. Jaundice and acute yellow atrophy of the liver;
3. Oedema and hydrops;
4. Albuminuria and nephrosis; pre-eclampsia;
5. Eclampsia.

The hypertensive cases, which constitute a large percentage of the so-called toxemic cases, are in reality not due to pregnancy toxemia, but are classified medically as "essential" or "idiopathic" hypertension.

I. EMESIS AND HYPEREMESIS

The vagus system and the vomiting center are stimulated by all the early pregnancy changes, including the molecular changes in the constitution of sugar, alcohol, and urea; the concentration of sodium and chloride ions; and early hormonal disturbance. Early vomiting is the result of a vagus hypertonia. As long as the vomiting comes from stimulation of the vegetative centers, the symptoms can be influenced by various treatments, all, however, practically psychotherapeutic in effect. DeLee says: "Probably a large part of our treatment is successful purely because the remedies make the patient think something curative is being done for her."

In pernicious or toxic vomiting, treatment must be directed to improve the viability of the cells. All nourishment by mouth is suspended and rectal or subcutaneous administration of bicarbonate of soda or of glucose is substituted to replace the loss of body fluid. Metabolic disturbances can be relieved by intravenous injections of serum, or by insulin in glucose, by calcium, or salts, and in some cases by Ringer's solution. Cholesterin and corpus luteum have also been given.

If symptoms of general toxemia develop, the clinical signs to be watched for are: Rise in temperature, rapid pulse, reduction in urinary

output, with appearance of tyrosin crystals and leucin in the urine, urinary sediment; sudden onset of jaundice, loss of weight, and dehydration.

The VanderBergh test and the icterus index give fairly accurate ideas of the degree of liver dysfunction. In cases of sudden onset of jaundice, or with an increasing index, with rapid pulse, immediate interference is indicated. Increase of retained nitrogen indicates increased albuminoid disintegration. Waiting too long in these cases may mean toxic irreversible cell destruction, and a positively poor prognosis even with interference. It is interesting to note that Bokelmann believes, "When hyperemesis gravidarum occurs in women who have a definite antipathy for pregnancy, they can be cured only by psychotherapy, if at all. If this form of treatment fails, the other forms will not be of any avail and gestation must be terminated."

II. THE JAUNDICE OF PREGNANCY AND ACUTE YELLOW ATROPHY OF THE LIVER

Physiological changes during pregnancy produce activity in the albuminoid, lipid, and carbohydrate metabolism, as well as blood changes in cholesterine content, etc. These changes largely deal with a correlated physiology of the liver activity. Even under normal condition we find increased bilirubin in the blood, and a slight fatty infiltration of the liver. Unquestionably the liver is taxed to its utmost functional capacity during the entire normal course of pregnancy. The failure of the liver to withstand its increased functional load is designated as "Hepatic insufficiency".

Pernicious vomiting during the last trimester is most frequently associated with a primary hepatic insufficiency. Increased and ever-constantly increasing metabolic changes lead to a definite liver pathology, with a symptom complex manifested in *persistent vomiting, rapid pulse, and sudden onset of jaundice*. Recurrence of hepatic insufficiency with vomiting, jaundice, etc., has been reported in the same woman in five or six subsequent pregnancies.

Cases will quite frequently have pernicious vomiting in the last trimester of pregnancy, having a temperature, a rapid pulse, a high icterus index, a positive VanderBergh test, and increased N.P.N. which should be carefully watched. These cases in

my opinion are types of increased fatty infiltration of the liver due to disturbed albuminoid, lipid, and carbohydrate metabolism, as well as blood changes in the cholesterin content. There are cases of pathological hepatic insufficiency, and if gotten early enough, properly treated, and carefully watched, will promptly recover.

I have a case at the present time under observation making a wonderful recovery, showing all the evidences of hepatic insufficiency and fatty infiltration with a liver reaching to the umbilicus. She has now ceased vomiting, the liver is going down under colonic treatments, sedatives (straganoff) of bicarbonate of soda and glucose, intravenously.

In certain cases a stationary jaundice exists during the entire pregnancy, without change of character as to color or degree. The patient presents a sallow complexion, and is in constant danger of acute yellow atrophy of the liver. The majority of children borne by patients with toxic idiopathic jaundice are born either prematurely or dead.

There is no treatment other than a general dietary one. Differential diagnosis must of course eliminate cholelithiasis, catarrhal jaundice, etc. The clinician must always watch his patient *for an increasing icteric facial tinge*.

The sudden onset of jaundice together with rapid pulse following or accompanying vomiting in the third trimester demands immediate cessation of pregnancy, because one can never tell which particular patient will develop acute yellow atrophy, since it may follow even a simple catarrhal jaundice. With acute yellow atrophy, the icterus *suddenly* becomes very intense, vomiting sets in, and the general condition of the patient is extremely grave. If jaundice precedes vomiting, acute yellow atrophy probably has already developed; while if vomiting precedes jaundice, acute yellow atrophy is liable to occur shortly preceded by an increased fatty infiltration. In either case, persistent vomiting in the last trimester is a serious symptom with a relatively frequent appearance of yellow atrophy.

Interference should be instituted as soon as the first symptom of liver involvement occurs. I have found that the best prodromal sign is a sudden rise of pulse rate: 120 or over is usually followed by jaundice. The important point is to interfere sufficiently early to gain any results from surgery. If the atrophy of

the liver already exists, interruption of pregnancy will not save the patient.

Every case of long-standing jaundice during pregnancy should be viewed with apprehension until the etiology has been definitely cleared. Until this is done, each case must be regarded as a toxic idiopathic icterus which, I believe, is an edematous fatty infiltration. If the etiology cannot be unquestionably determined, it is safer to interfere to forestall a possible development of yellow atrophy, resulting in death to both mother and child. If pregnancy is uninterrupted, the final complication will be a purpura hemorrhagica from the skin, together with mucosal bleeding, followed by coma and death.

III. OEDEMA OF PREGNANCY

Bogginess of body tissue and organs, and their predilection to oedema during pregnancy is physiological; and it is only when oedema increases to a more or less general character that we are dealing with a *pregnancy hydrops*. Prenatal management should then become active to prevent a physiological condition from becoming pathological. Most frequently the lower extremities, the vulva and the abdominal wall are involved. In severe cases the entire integument becomes dropsical.

Toxic disturbances are caused by fluid and sodium chloride retention within the tissues. During the beginning of true hydrops of pregnancy, kidney disturbance is absent. No albumin or other pathological substances, as casts, blood-cells, etc., are found in the urine. Blood chemistry is negative, and the Volhard test is almost always normal. However, if hydrops is allowed to become long-standing, or if dropsical accumulation becomes more extensive, then frequently the kidney function will be involved.

Prophylactic treatment to prevent the development of extensive oedema and therapeutic treatment to get rid of it must be carried out by prohibition of salt ingestion except in the form of small amounts of vegetable salt; by cutting down the fluid intake; by reduction of protein in a diet with little or no meat, which stresses the use of milk, vegetables, and glucose.

In addition, I make use of a simple mechanical device to aid elimination from the kidneys.

I have my patients raise both legs high for a certain period of time, daily, while lying on the back. The increased output of urine, in comparison to the fluid intake, an hour or two after this callisthenic exhibition, demonstrates how excellent an organ of elimination the kidney is. This elevation of the limbs is done as a routine measure, with careful tabulation of intake and output, as well as a study of the immediate marked reduction in the oedema, especially of the lower extremities. Its success has convinced me that the engorgement of the tissues, due to the extra work put upon the kidneys, can in some measure be relieved.

Patients with oedema must be seen frequently and watched for the onset of nausea and vomiting and examined for early contraction of the retinal vessels of the eyegrounds. The power of tolerance of the kidney must be determined by functional tests and urinary examinations. Blood chemistry studies, which have long been regarded as futile in these circumstances, are again being stressed.

Careful observation and proper treatment will, in the greater number of these cases of oedema, prevent the development of nephrosis and eclampsia. The non-pathological character of this type of oedema is demonstrated after delivery by the greatly increased urinary output without kidney involvement.

IV. ALBUMINURIA AND NEPHROSIS. PRE-ECLAMPSIA

During the latter months of pregnancy, and especially during labor, occasional cylindroid casts and a small amount of albumin are regularly found in a large number of cases. As long as the albumin remains below one per cent, one is dealing with a physiological albuminuria of pregnancy and labor. This proves that the kidney even normally is subjected to sufficient functional strain to develop, if not watched, pathological changes and exfoliative manifestations of the glomeruli cells; and finally to involve the recti-cells and produce an incipient nephritis. This happens when the amount of excreted albuminar urea and casts increases to a point indicating, not Bright's disease, but a borderline beginning nephritis. This may not have great pathological significance,

but medical treatment is indicated although the kidney function may be good with normal urine concentration. The blood pressure is as a rule only slightly elevated, but in exceptional cases may be very high. It is very difficult, and sometimes almost impossible, to differentiate between a nephritis, and a nephropathia of pregnancy.

Clinically there are two forms of what has been called "Pregnancy nephrosis"—a poor term for a condition which is much better expressed as "Borderline kidney threshold".

The first form (low reserve kidney) runs a more or less chronic course, characterized by oedema; a large output of albumin; relatively light subjective symptoms; but with rare occurrence of eclampsia.

The second form, the acute type, may show an entire absence of oedema in the beginning or throughout; frequently only a small amount of albumin; the early onset of headache of severe intensity, nausea, epigastric pressure, vomiting, impaired misty vision with blurring; and a very high blood pressure in the greatest number of cases.

Under medical treatment the blood pressure may drop, only suddenly to shoot up to 200 and over, with a corresponding increase in the number of casts and decrease in the amount of urine. *Lack of success with conservative treatment is an absolute indication to terminate the pregnancy.* As a rule, however, if the patient begins to improve, convalescence is very rapid. On the other hand, not infrequently albuminuria and casts continue to be seen for weeks and months after pregnancy is terminated. The extent of their disappearance, and the amount of time required, gauge the extent of damage to the kidney. It thus appears that a typical chronic nephritis can be the termination of a nephropathic pregnancy; the patient has no longer a true nephrosis, but a mixed form of nephrotic change with the glomeruli and the recti tubules both involved, a glomerular nephritis.

The acute form of pregnancy nephrosis is called *pre-eclampsia*, since all its symptoms predispose to convulsions which are daily and hourly threatened. Primiparae are most frequently sufferers from this condition. Recur-

rences in future pregnancies occur in about two per cent of the cases; individual women have presented recurrences in as many as eight to ten subsequent pregnancies.

Pre-eclamptic treatment consists in the regulation of diet and the administration of glucose and morphine. Colonic irrigations containing five per cent glucose may be given every two hours. If, however, the patient's blood pressure rises to over 140, then dietary treatment is useless.

The adrenalin test is here a great help; it has given me good service in all cases of pre-eclampsia. If it is positive, it indicates a sympatheticotonia. The more affirmative the test, the more threatening the advent of convulsions, and the stricter the treatment. Even in the absence of all other signs, if the positive adrenalin reaction is present, it calls for energetic prophylaxis such as rest in bed, starvation, and dehydration, together with all other prophylactic precautions, for three days. Such treatment in many cases prevents the onset of convulsions.

THE ADRENALIN TEST

Adrenalin stimulates the sympathetic system. All the pronounced manifestations which present themselves following stimulation of the sympathetic system from constitutional or organic conditions, etc., are also produced after adrenalin 1:1000 injection. Previously adrenalin was injected subcutaneously in 0.5 to 1.0 mg. doses. It was found, however, that its subcutaneous absorption varied so from case to case, that this method of test was discontinued; and 0.01 mg. of adrenalin solution was used intravenously. The reaction following the injection is:

1. General restlessness.
2. Tachycardia or palpitation.
3. Very pale skin.

This reaction is particularly marked in patients with an increased sensitivity of the sympathetic nervous system, or a sympatheticotonia as described by Eppinger and Hess. In these types the injection also causes a rise in blood pressure, even to 150 Hg. rise, of ten minutes' duration, after which the blood pressure gradually lowers. The pulse becomes slower, and may reach 30 beats with an increase in respiration. The latter sign only occurs in the presence of vagotonia.

In the presence of an undisturbed blood pressure without any rise but a definite slow *pulse beat*, I believe one is dealing with a vagotonia (which can be verified by the Ascher, or ocular sign). This is to be remembered because small doses of adrenalin can so stimulate the vagus, as well as larger doses obscure its influence on the vagus through the sympathetic as related to toxicosis and liver physiologic pathology, etc. Adrenalin injection after ten min-

utes of its intravenous instillation is usually followed by a hyperglycemia as well as by a glycosuria. This metabolic manifestation, however, is conditional to the glycogenic content of the liver and the kidney tissue permeability for glycogen.

At the beginning of the intravenous adrenalin test a lymphocytosis, with an increase of polymorphous leukocytes, occurs.

The ocular test with 1:1000 adrenalin reacts in the form of mydriasis in the presence of a stimulated physiologic-pathological sympathetic nervous system. The adrenalin test frequently differentiates between a physiological pathology and a definite toxic pathology in toxicosis of pregnancy.

In a true nephrosis the glomeruli remain uninvolved and function is normal; the main pathology is in the recti tubules where there are marked degenerative processes. White infarcts are often seen in the placenta in these cases. Premature placental detachment occurs in true kidney disease not infrequently, accompanied by serious hemorrhage from a retro-placental bleeding.

The differential diagnosis between an idiopathic kidney nephrosis, and an acute or a chronic nephritis, is most important. During pregnancy, acute nephritis may also arise from focal sepsis in the mouth or throat (teeth or tonsils), or following angina or other infectious diseases. In cases with chronic nephritis, albuminuria and oedema develop as first signs during the early months of pregnancy; in the nephropathies, on the contrary, they appear as first signs during the last months of gestation. As a rule, this consideration helps roughly to establish the differential diagnosis. When complicating conditions obscure the clinical picture, an internist must be consulted.

V. ECLAMPSIA

Eclampsia is *toxemia with convulsions*. It is not limited to any special etiology or toxemia, but may appear with a great variety of symptoms, such as oedema, vomiting, vertigo, headache, retinal changes, albuminuria, hypertension, and jaundice. The combinations of symptoms manifested vary with the individual patients. Hypertension, as has sometimes been stated, is not the only constant symptom of the late toxemias. The clinical symptoms and pathologic lesions do not always correspond. In cases coming to autopsy, there are always

characteristic eclamptic lesions in the kidneys (tubular necrosis and glomeruli lesions) and periportal hemorrhages and necroses of the liver. These are also found in non-eclamptic toxemia.

Neglected or improperly treated cases of toxemia will only too frequently develop convulsions. These attacks are usually preceded by symptoms of nephropathia, but on occasion the first convulsion may occur as a complete surprise, with the patient falling suddenly to the floor with a toxic contracture and convulsion which ends in coma. The eclamptic attack may be followed by a memory aphasia,—a psychosis with predominatingly nervous manifestations. These symptoms are usually transitory, but they may be prolonged. They should be treated with sedatives. One-half grain of morphine may be given immediately, and one-quarter grain with each succeeding fit; two hours should elapse between administrations—and then 1/150 grain of atropin with oxygen is given. The barbiturates must be administered with caution, since a case of fatal agranulocytosis has been reported from their use in eclampsia.

Colonic irrigations given with three to four gallons of a five per cent glucose solution, and requiring a full half-hour's time, may be of benefit. After the bowel is thoroughly cleansed, the irrigations may be repeated, at first, every six hours, then twice daily, and finally, once a day, as the patient improves.

If the patient's blood pressure continues to be high, bleeding may be of advantage. It gets rid of toxic material, and reduces oedematous congestion. Five hundred to 600 c.c. or even more of blood may be removed by slow extraction; after this, hyperdermoclysis or very slow-flowing continuous intravenous injections are given. Personally, I do not like intravenous instillation, since it may disturb thrombi, overload the enlarged heart, the oedematous kidney, or the brain; and also may produce hemorrhage or detach necrotic tissue.

Cerebral tension may be eased and convulsions forestalled by means of a spinal tap, which has the added advantage of differentiating between cerebral oedema and brain hemorrhage. In some cases it has been repeated for

the sake of the relief obtained. One continental authority has advised regular spinal taps to relieve intracranial pressure and to lower intraspinal pressure, in view of the fact that the more numerous the convulsions, the more liable the development of mental sequences.

Eclampsia may develop in any one of three periods: 1, During the last three or four months of pregnancy; 2, more frequently, during labor; and 3, during the puerperium. Labor pains have a definitely predisposing influence towards inducing convulsions; and conversely, convulsions have an inductive effect on labor pains. During labor, eclampsia is of more unfavorable significance than during the puerperium.

Eclampsia may also appear in an atypical form without convulsions. It is then characterized by severe headache, visual disturbances, high tension pulse, hypertension, and reduced urinary output with abundant albumin and casts, followed by pronounced attacks of unconsciousness, with twitching of individual facial and hand muscles. The patients usually recover and the attacks are rarely recognized as truly eclamptic. In case of death, however, post-mortem findings will always show true eclamptic lesions in the liver and kidneys.

Pseudo-eclamptic convulsions may arise during pregnancy from epilepsy, meningitis, brain tumor, etc., but these are relatively easily distinguished by differential diagnosis.

The prognosis of eclampsia is always doubtful. The more prolonged the coma, the more serious the condition. Favorable and unfavorable surprises are characteristic. Thus, while severe and numerous convulsions lessen favorable prognosis, nevertheless the number alone may not warrant an unfavorable deduction, since women who have had one hundred fits have been saved; while others have died after the first seizure. Sometimes even if convulsions have ceased and the patient is apparently recovered, eclampsia may have a fatal outcome. Cases complicated by jaundice are almost invariably fatal. Clearing up of mental symptoms between attacks is a favorable sign. A small urinary output or complete anuria are ominous symptoms. In the presence of com-

plete anuria, kidney decapsulation, as advocated by Edelbohls, gives the kidneys more room for distention, but this should be considered only as an extreme resort. When the kidney or the liver has suffered too great damage, even abdominal section will not save the mother although a live child may be delivered.

The maternal mortality in eclampsia has ranged in the past from 15 to 20 per cent, and fetal mortality has been as high as 50 per cent. At present, modern treatment has reduced maternal mortality to ten per cent, and even less.

The accepted treatment of eclampsia follows three lines:

1. The conservative method, i. e., treating the eclampsia as such, with later delivery, when it is possible, by the natural passages, although most cases will deliver themselves.
2. The active method, that is, immediate delivery by abdominal section.
3. The middle course, with treatment of eclampsia induction and hastening labor by bagging, version, and forceps, as soon as possible.

Conservative methods should always be tried first, and the symptoms carefully watched, unless the patient is in labor. Then, if the cervix is dilated, she may be delivered at once by Potter version. If the cervix is *fully* dilated, the Braxton Hicks technic is used. The operator should not forget to perform a pudic block for relaxation of the levato ani muscle, and for prevention of tears. If the fetal head is down to the third plane, under proper conditions, delivery with forceps is indicated.

Under certain conditions more radical measures are called for. One should always remember, in cases of eclampsia, that toxic symptoms frequently recur after conservative measures have been temporarily successful. Consequently, the surgeon should be on guard always to prevent eclamptic attacks from destroying the organic functions of the liver and the kidneys beyond hope of repair. If the patient's temperature is high, she should be delivered at once, either by Caesarean section, or from below.

If conservative treatment has failed, or if the cervix is closed and the mother is in dan-

ger, section should be resorted to. This does not hold for hepatic cases when jaundice is present because of secondary postoperative hemorrhage. If the patient has an ample pelvis, it is better to do a version, and sacrifice the child. In certain other cases, however, abdominal section offers the best results because it obviates labor pains. Labor pains, of themselves, have a super-irritating effect on the nervous system, increase the blood pressure, and dispose the patient to new convulsive seizures.

As eclamptics are easily infected, the question every now and then arises: Why permit so much trauma? Section is easily done, is less dangerous, and is not liable to have an ill effect on future deliveries; whereas too great injury from prolonged convulsions and from labor trauma is likely to leave permanently damaged kidneys which form an insuperable contraindication to future pregnancies.

SUMMARY

Prophylaxis is the best preventive of toxemia and eclampsia. Premonitory signs, appearing collectively or alone, occur in 80 per cent of all the cases. The most important of these is headache which is severe and of increasing intensity.

Kidney changes cannot be classified as of objective importance because albumin and lipid products are often found in the urine in pregnancy, due to normal important alterations going on during the osmosis of the kidney filter. Consequently, within certain limits, kidney changes are not indicative of eclampsia. On the other hand, definite anuria or scanty urine containing relatively small amounts of albumin but with hyaline, granular, and cylindrical casts, does indicate kidney damage. These indications, if not relieved, demand active treatment, since, if they are neglected, they may result in a permanently damaged kidney. Whenever the three casts are present, and urobilinogen, acetone, and acetic acid are also found in the urine, late liver and kidney damage is definite. In these cases only interruption of pregnancy by section is likely to save the patient.

The toxemic syndrome and its degree of intensity are predicated by the following symptoms, either alone or in combination: Headache, increased vomiting, sleeplessness, nervousness, eye-ground disturbances (blurred vision), continuous nausea, general pruritus, and high blood pressure (180-200). Muscular irritability is an early sign of pre-eclamptic toxemia. Tested with the galvanic current, muscle irritability, toward the end of normal pregnancy, is regularly increased to a galvanic sensitivity of 1.5 to 1.8 milliamperes. In pre-eclampsia, sensitivity is raised to 3.6 milliamperes before muscle fibrillation can be produced. The lower the galvanic sensitivity, the better the prognosis in pre-eclampsia.

The pathology in toxemia cases is not confined to one organ but is general, with involvement of the liver, kidney, heart, and brain, as the most typical lesions. All changes are typified by numerous hemorrhagic areas and necroses, sometimes diffuse, varying in size from that of a pea to a hand, which arise from multiple thromboses. The serious complications of toxemia are: glomeruli nephritis, atrophy of the kidney, and amyloidosis of the liver.

It should be noted that it takes just as long for a pre-eclamptic patient to get rid of her subjective symptoms and objective changes, during the puerperal period, as it does for the outspoken eclamptic; consequently, the pre-eclamptic patient should have exactly as careful watching for three months as does the eclamptic. In both these types of patients, a raised blood pressure and a urine of low concentration, containing albumin, red cells, casts, and lipoids, may continue to be present. Their degree predicated the extent of kidney damage.

Eclampsia is not a disease with its own etiology. It is the symptom and the terminal result of a long-standing condition which should have been recognized and properly treated during pre-natal care. For this reason, we are hearing less today about eclampsia cases, and more of the toxicoses and toxemias of pregnancy.

In closing, it might be said that women with chronic hypertensive disease and chronic kid-

ney disease are not fit subjects for pregnancy. They can never bring pregnancy to a successful termination, and either die or intensify their disease. In the normal woman, leading a relatively comfortable life, and without chronic

disease, we should be able, barring uncontrollable accidents during pregnancy, to raise the statistics of successful labor, by a still further reduction of the incidence of toxemias and eclampsias.

THE CLINICAL MANIFESTATIONS AND MANAGEMENT OF EARLY SYPHILIS

By GIRSCH D. ASTRACHAN, M.D., New York, N. Y.

Abstract of a paper read before the Summit Medical Society, Summit, N. J., September 28, 1937.

Syphilis is a real blood disease, because within forty-eight hours after the infection, the disease spreads through the lymph and blood system to almost every part of the human body. It is caused by an organism, *Spirocheta pallida*, which cannot survive exposure to air and light. Moisture, however, helps the survival and multiplication of the spirocheta. Therefore, organs like the mouth, vagina, fore-skin and objects such as pipes, cups, etc., may cause the transferring of the disease.

Three to six weeks after the infection there develops on the site of infection the primary lesion of syphilis—the *chancre*. It may be variously sized and shaped, but the typical chancre is a well-defined, somewhat elevated, hard, eroded lesion, covered by a faint grayish pellicle, and surrounded by a hemorrhagic line. It seldom ulcerates, and is almost always accompanied by indolent enlargement of the adjacent lymph glands. Ten to fifteen per cent of the primary lesions occur extragenitally—on the lips, face, nipples, and so on.

The secondary stage of syphilis may be manifested by malaise, weakness, headaches, sore throat, or loss of hair. The rash has several characteristics. It is generalized, symmetrical, indolent (does not itch). The lesions are somewhat infiltrated, discrete, and heal spontaneously. The disease is very contagious at this time, due especially to the presence of mucous patches, which are nothing else but eroded syphilitic papules, mostly in the mouth, around

the genitalia and anal region, and are caused by moisture and traumatization.

The rash may pass through different successive stages and appear in the form of macules, papules or pustules. An early diagnosis is most important. No suspicious case must ever be neglected through the failure to use the darkfield examination, or the Wassermann or other blood tests.

A spinal-fluid is never to be taken at this time, as the passage of the needle through the tissues may carry the infection to the central nervous system.

Early syphilis is the period which elapses from the time of inoculation up to the time of the disappearance of the secondary eruption (including late secondary manifestations). After the chancre lasted three or four weeks, the Wassermann test of the blood is positive in about 80 per cent of the cases.

Before any active treatment is given, a complete physical examination must be made. With a severe heart condition, salvarsan may cause instant death. With the presence of nephritis, the mercurial or bismuth therapy may cause further damage to the kidneys. A careful eye examination must be made, as a heavy dose of salvarsan may impair the sight, or cause total blindness.

The *psychological approach* to the patient is most important in order to have him follow the long and strenuous routine of treatment necessary to cure this condition. The physician

must be truthful, and explain all pertinent details; and he should not make the patient feel that he is an "outcast". After two or three weeks of treatment with salvarsan and bismuth, the condition is not highly contagious (through direct or indirect physical contact); and the patient may go freely about the community.

Sero-negative primary syphilis can be cured in 100 per cent. Primary sero-positive and secondary syphilis may be cured in 90-95 per cent of the cases. Treatment must be very vigorous for at least one year after the Wassermann becomes negative; or for a period of one and one-half years.

Dr. Astrachan employs the concurrent method, using salvarsan and bismuth, each once weekly. He advocates the *continuous* treatment, and believes that the interrupted method may cause a delay in the reversal of the blood test, and other complications, and is not as effective in the treatment of early syphilis. The alternate method may be used for weaker or debilitated persons.

The use of mercury has been almost completely abolished, except mercury inunctions, or in cases where bismuth cannot be tolerated.

One year after infection, a spinal fluid test is taken. If this is negative, and if the blood

serology remains negative for two more years, the case is considered cured. The person should not marry for five years after he was infected.

Reactions following the injection of salvarsan may generally be prevented. Each patient must be questioned, before each arsenical treatment, as to whether he had any after-effects such as pruritus, or eruption after the last injection. If a reaction was present, the injection of the arsenical must be stopped, and a blood count and urine examination and study of the eyegrounds must be made.

An Jarisch-Herxheimer reaction, or *therapeutic shock*, presents an acute flare-up of the syphilitic manifestations due to the liberation of toxins of the living spirochetes. It may cause serious consequences if it occurs in the eye, heart, or central nervous system. The Herxheimer reaction may be avoided by the use of one or two preliminary injections of bismuth before administering arsphenamine.

The nitritoid crisis may be controlled by adrenalin. With the presence of jaundice, salvarsan must be stopped and not used for three months after the jaundice disappears. It may be renewed with small doses; but if the jaundice reappears, arsenicals must be stopped and never renewed. The presence of urticaria is not a serious reaction. With exfoliative dermatitis, salvarsan must never be given.

MATERNAL MORTALITY STATISTICS 1938

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey; and
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,
State Department of Health.

Each year the Committee on Maternal Welfare of The Medical Society of New Jersey publishes its maternal mortality statistics showing how the State stands and what each county has accomplished during the year.

These figures are as accurate as can be obtained for the following reasons:

1. Each maternal death is investigated by the Field Physician in the county in which the death occurs, and all the important facts are obtained. Occasionally, due to careless filling out of the death certificate, a death listed as a maternal death is found wrongly classified. Care should be taken to record facts as they are. Interns frequently give a wrong diagnosis. For this reason the committee has requested that interns do not fill out the maternal death certificate without the endorsement of the attending physician.

2. An annual report is received from practically every hospital in the State taking obstetrical cases. Over 95 per cent of the reports for 1938 were received during the first three months this year. On examining these reports, deaths were found reported which had not come to our attention. The hospital considered them maternal deaths, but the Statistical Department of the State Department of Health had not classified them as such, owing to a carelessly filled-out death certificate.

As a result, it was necessary to add ten maternal deaths to the list received from the State Department of Health. Following these procedures the maternal mortality rate for 1938 was found to be 3.5 per 1,000 live births, or 35 per 10,000. There were 56,042 live births in the State in 1938.

The percentage of patients being delivered in hospitals is gradually increasing. In 1938, 78.6 per cent of the deliveries were in hospitals; 17.7 per cent were delivered at home by physicians; and 3.7 per cent were delivered at home by midwives.

Essex County, with the greatest number of live births a year (12,042 in 1938), had 90.5 per cent delivered in hospitals,—the highest percentage of any county in the State. Hudson County, with the next greatest number of live births (9,006 in 1938), had 88 per cent delivered in hospitals.

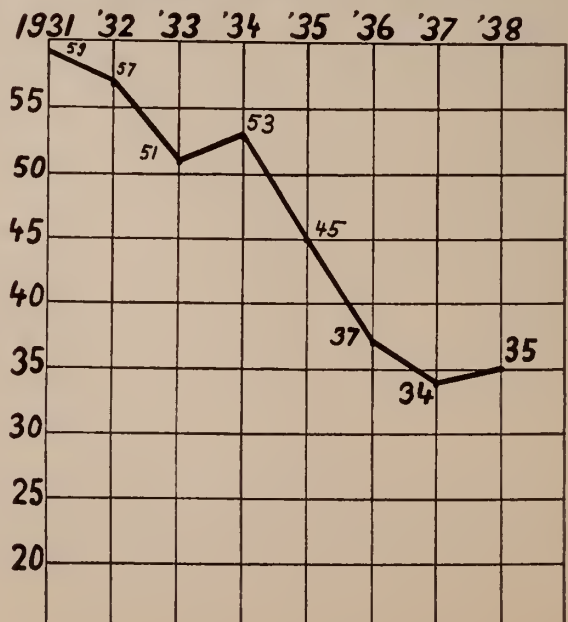
New Jersey has a higher percentage of colored births than any other Northern State. The death rate among colored patients is higher than among the white, largely due to puerperal sepsis and septic abortions; but the rate has been gradually decreasing to 54 per 10,000 for 1938, the lowest for New Jersey.

The maternal mortality rate for the white patients was 34 per 10,000 in 1938, an increase of three points over 1937.

EXHIBIT I

This graph shows the maternal mortality rate for each year since 1931, when the State Committee on Maternal Mortality was ap-

Maternal mortality statistics for the State of New Jersey for each year since 1931.



pointed. The increase in the rate for 1938 was due to a rise in number of deaths from puerperal hemorrhage and other accidents of childbirth in urban counties, and an increase of puerperal sepsis and puerperal hemorrhage in the rural counties.

In the urban counties 81.9 per cent were de-

livered in hospitals; 14.2 per cent were delivered in homes by physicians, and 3.9 per cent were delivered in homes by midwives.

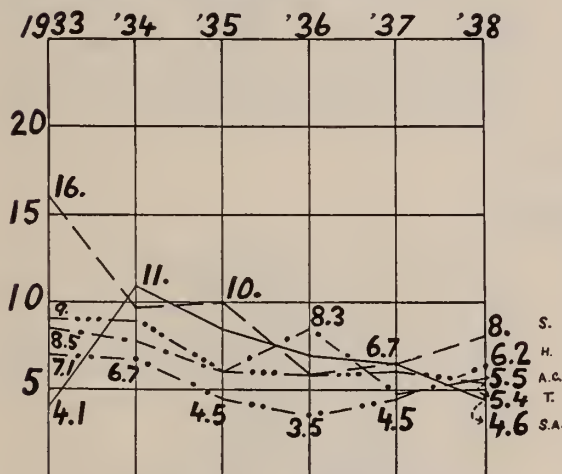
In the rural counties 52.8 per cent were delivered in hospitals; 44.7 per cent were delivered in homes by physicians; and 2.4 per cent were delivered in homes by midwives.

EXHIBIT II

This graph begins with 1933, because this was the first year septic abortions and puerperal sepsis were classified separately.

EXHIBIT II

Graphs of maternal mortality rates in New Jersey for each 10,000 live births, according to the main causes of deaths, during the past six years, 1933-38.



PUERPERAL SEPTICEMIA — — —
SEPTIC ABORTION —————
TOXEMIAS OF PREGNANCY — · · · —
PUERPERAL HEMORRHAGE — · · · · —
OTHER ACCIDENTS OF CHILDBIRTH — · · —

In 1938 the maternal mortality rate for puerperal sepsis in the rural counties was over twice as high as a whole as the rate in the urban counties. More care should be taken in carrying out aseptic technique in all deliveries. Puerperal sepsis is largely preventable.

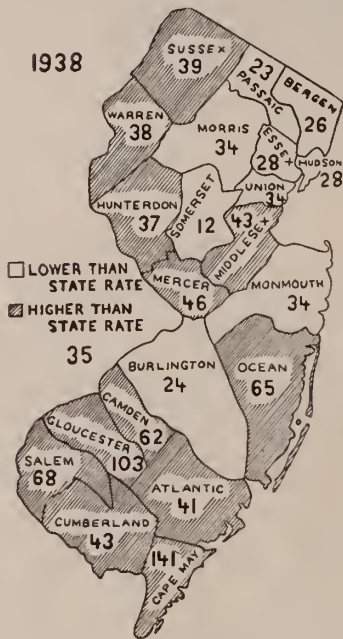
The rate for toxemias of pregnancy was over three times as high in the rural counties as the urban counties. Toxemia of pregnancy is largely preventable. Scattered cases which have little or no prenatal care develop severe toxemia causing a maternal death. Each county should have a comprehensive system of prenatal care to prevent these deaths.

In the urban counties puerperal hemorrhage and other accidents of childbirth have a higher rate than the rural counties. It should be noted that a greater percentage of the urban cases are delivered in hospitals. These deaths can be reduced by closer attention to the following points: (1) See that the patient is in as good condition as possible before labor starts. (2) Interfere as little as possible with labor. (3) Beware of excessive doses of analgesics.

EXHIBIT III

EXHIBIT III

Maternal mortality rates per 10,000 live births by counties in New Jersey, in 1938.



Seventy per cent of the live births in the State (39,694) occurred in the white (unshaded) counties, with a maternal mortality rate of 27 per 10,000; while the shaded counties, or those with rates higher than the State rate, had 30 per cent of the total live births of the State (16,348), with a rate of 55 per 10,000 live births.

The urban counties had 88 per cent of the total live births of the State (49,339), with a mortality rate of 34; and the rural counties had 11 per cent of the State total, with a mortality rate of 50 per 10,000.

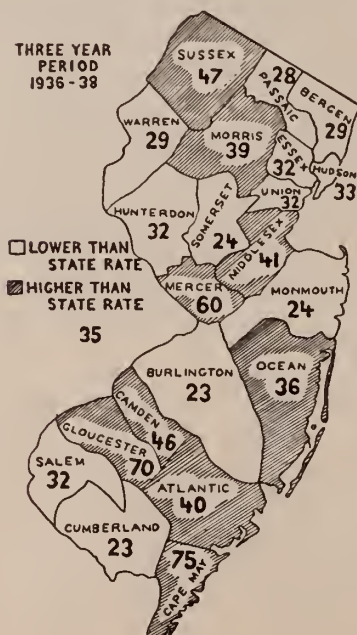
The four counties with the largest number of live births, Essex, Hudson, Passaic, and Union (all urban), had 55 per cent of the total live births (30,847), with a maternal mortality rate of 27 per 10,000.

Because some of these counties are lower than the State rate as a whole does not signify that they are low in all classifications. The following maps should be studied carefully for rates on the principal classifications.

EXHIBIT IV

EXHIBIT IV

Maternal mortality rates by counties, for the three-year period, 1936-38.



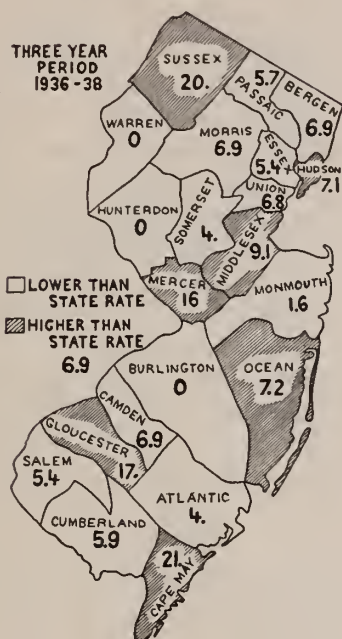
The three-year period is used for the following maps as some of the rural counties have only about 300 live births a year, and a more accurate comparison can be made with counties when there are at least one thousand live births.

The white, or lower than State rate, counties represent 73 per cent of the State total of live births with a rate of 30 per 10,000; and the shaded, or higher than State rate, counties represent 27 per cent of the State total with a rate of 48 per 10,000 live births.

The urban counties had 87.3 per cent of the total live births with a rate of 35 per 10,000, and the rural counties had 12.7 per cent of the total live births with a rate of 36 per 10,000.

In comparing this three-year period (1936-37-38) with the previous three-year period (1933-34-35), there was a decrease of 30 per cent in the State rate of maternal mortality.

EXHIBIT V

EXHIBIT V
Puerperal Septicemia

RATES ARE PER 10,000 LIVE BIRTHS

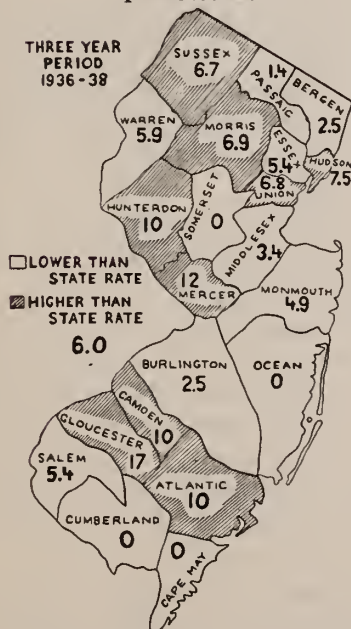
The white, or lower than State rate, counties had 69 per cent of the total live births of the State for this three-year period, with a rate of 5.4 per 10,000; and the shaded counties, or higher than State rate, had 30 per cent of the total live births for the same period, with a rate of 10 per 10,000 live births.

The urban counties had a rate of 6.8 per 10,000; and the rural counties had a rate of 7.1 per 10,000 live births.

There has been a greater decrease in the rate for puerperal sepsis in the rural counties in this three-year period over the previous three-year period (1933-34-35) than in the urban counties; however, the rate is still too high. There was a decrease of 42 per cent in the State as a whole.

Over a period of five years Essex County, with 57,025 live births, had the lowest average rate for the urban counties. The highest average rate for five years was Gloucester County, with 4,846 live births, rate 18 per 10,000; and Cape May County, 1,706 live births, rate 17 per 10,000 live births.

EXHIBIT VI

EXHIBIT VI
Septic Abortion

The lower than State rate, or white, counties had 45 per cent of the State total live births,

with a rate of 3.6 per 10,000; and the higher than State rate, or shaded, counties had 54.9 per cent of the total live births, with a rate of 9 per 10,000 live births.

Urban counties had a mortality rate of 6.2 per 10,000, and rural counties had a mortality rate of 4.8 per 10,000 live births.

In comparing this three-year period with the previous three-year period (1933-34-35), there is a greater decrease in the rural rate than in the urban rate. The total State rate decreased 23 per cent.

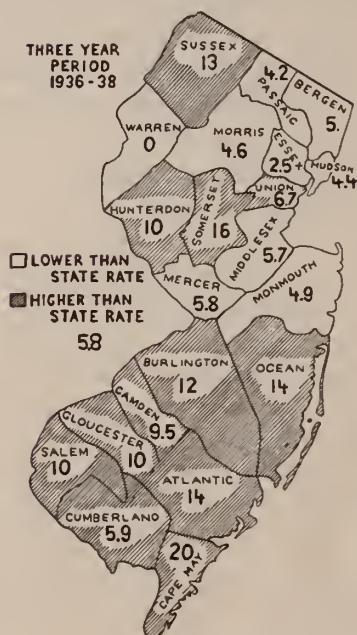
Ocean County (rural) has had no deaths from septic abortion in six years.

Over a period of five years, Ocean County has the lowest rate—zero—for septic abortion, with 2,332 live births.

Somerset County is second, with a rate of 2.2 in 4,411 live births.

Bergen County has the lowest average rate of the urban counties for five years,—rate 3.2 per 10,000, with 21,383 live births.

EXHIBIT VII

EXHIBIT VII
Toxemia of Pregnancy

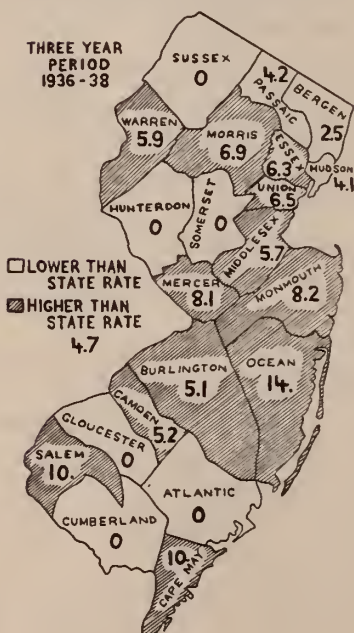
White, or lower than State rate, counties in this group had 70 per cent (115,981) of the State total of live births, with a rate of 4 per 10,000; and the shaded counties had 30 per cent (48,813) of the State total of live births, with a rate of 10 per 10,000 live births.

With the exception of Warren County all the other white counties are urban. The urban counties had 87.3 per cent, or 143,946, of the State total of live births, with a rate of 5 per 10,000; and the rural counties had 11.7 per cent, or 20,848, of the State total with a rate of 11 per 10,000 live births.

In comparing this three-year period with the previous three-year period (1933-34-35), the urban counties decreased their rate by 25 per cent and the rural counties decreased 15 per cent.

Over a period of the last five years, Warren County (rural) had no maternal deaths from toxemias, with 3,037 live births; and Essex County (urban) with 57,025 live births had the second lowest rate, 3.6 per 10,000.

EXHIBIT VIII

EXHIBIT VIII
Puerperal Hemorrhage

The counties with lower than State rate, or white, had 49 per cent (81,277) of the State total of live births, with a rate of 2 per 10,000; and the counties with higher than State rate, or shaded, had 51 per cent (83,517) of the total live births for the State, with a rate of 7 per 10,000.

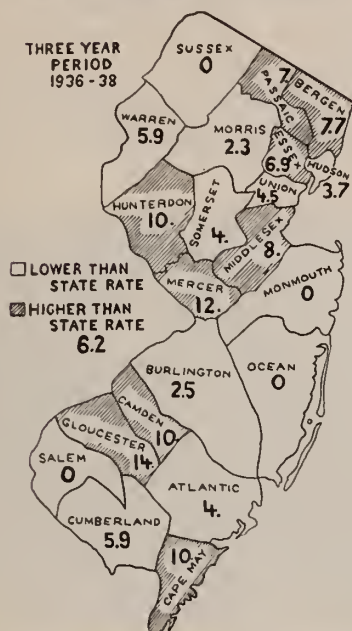
The urban counties had a rate of 4 per 10,000; and the rural counties had a rate of 3 per 10,000 live births.

In comparing this three-year period with the previous three-year period, there was a decrease of 36 per cent in the rate for the rural counties, and a decrease of 19 per cent in the rate for the urban counties. Cumberland, Hunterdon, and Sussex Counties, all rural, with a total of 11,525 live births, had no deaths from puerperal hemorrhage in six years.

Over a period of five years, Union County had the lowest rate for the urban counties,—2 per 10,000 with 21,709 live births.

EXHIBIT IX

Other Accidents of Pregnancy



The counties with rates lower than State, or white, had 43 per cent of live births of the State, with a rate of 3 per 10,000; and the shaded counties had a rate of 8 per 10,000 live births. The rate for the urban counties was 6 per 10,000 and the rate for the rural counties was 5 per 10,000 live births.

In comparing this three-year period with the previous three-year period (1933-34-35), the rate for the rural counties decreased 35 per cent and the urban counties decreased 14 per cent. The rate for the State as a whole decreased 17 per cent.

Salem County (rural) has had no deaths from other accidents of childbirth in nine years,—total 5,476 live births. In 1938, Salem County had 49.4 per cent of cases delivered in hospitals; 49.8 per cent delivered in the homes by physicians; and 0.3 per cent delivered by midwives.

Over a period of five years the second lowest rate occurred in Somerset County (rural), with 4,411 live births, rate 2 per 10,000 live births.

The lowest average rate for an urban county was in Hudson County, 44,417 live births, rate 3 per 10,000 live births.

No doubt, the consultation service the State Department of Health pays for has done considerable to reduce the mortality rate in the rural counties. A large number of the consultation slips are filled out; reason for consultation, "Prolonged labor" or "Dystocia"; advice given, "Watchful waiting"; and frequently a later notation, "Case delivered normally".

EXHIBIT X

Exhibit X shows the average record for the past three years (1936-37-38) for each county as to whether its rate is lower or higher than the State rate regarding the five principal causes of maternal deaths.

EXHIBIT X

Summary by Counties

	PUERPERAL SEPTICEMIA	SEPTIC ABORTIONS	TOXEMIAS OF PREGNANCY	HEMORRHAGE	OTHER ACCIDENTS OF CHILDBIRTH	WHITE	SHADED
ATLANTIC						3	2
BERGEN						4	1
BURLINGTON						3	2
CAMDEN						1	4
CAPE MAY						1	4
CUMBERLAND						4	1
ESSEX						3	2
GLOUCESTER						1	4
HUDSON						3	2
HUNTERDON						2	3
MERCER						1	4
MIDDLESEX						2	3
MONMOUTH						4	1
MORRIS						3	2
OCEAN						2	3
PASSAIC						4	1
SALEM						3	2
SOMERSET						4	1
SUSSEX						2	3
UNION						2	3
WARREN						4	1

WHITE BLOCKS - LOWER THAN STATE RATE
SHADED BLOCKS - HIGHER

White indicates a rate lower than that of the State; and shading indicates a rate higher than the State rate. The records show a variation from four white for six counties, to four shaded for four counties.

CONCLUSION

It is hoped that every physician in New Jersey taking obstetrical cases will study these statistics, in an effort to improve them next year. Often we do not realize how many preventable deaths there are. We hear of only one here and there.

There are certain essentials necessary in every county.

1. Has your county a comprehensive system of prenatal care for the indigent and low-wage groups? If not, you cannot maintain a low rate of maternal mortality.

2. Has your county adequate hospital facilities? If not, why not start a drive for an improvement in this important detail? Why be satisfied to work with inferior equipment? The public expects from you a perfect record.

3. Why not take a little more pains with the simple normal case and thus avoid accidents?

4. Why not call a consultant early in all abnormal conditions?

5. Why not enforce rules in hospitals for closer supervision and more conservative treatment? Interns should have more supervision. This is a valuable opportunity for them to learn conservative obstetrics.

The committee appreciates the splendid cooperation of the physicians, nurses, hospitals, and the State Department of Health.

OUR MOTTO

"Adequate Supervision and Care for Every
Expectant Mother in New Jersey."

A LESSON FROM A DEATH CERTIFICATE

NUMBER ELEVEN

Patient, aged thirty-eight years, admitted to hospital with hypertension. Two days later complained of *substernal* pain. No other symptoms.

Why look for more symptoms? Is not the

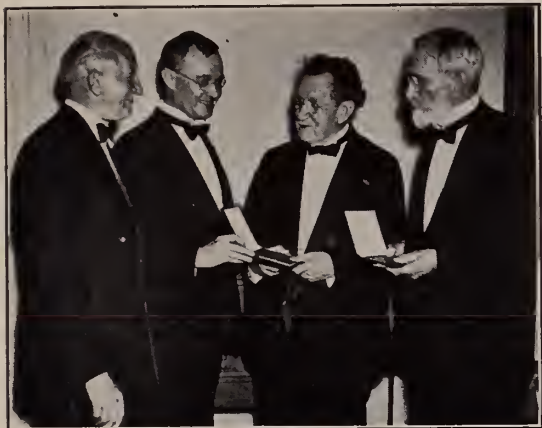
substernal pain in a patient with hypertension a danger signal?

Patient had convulsions next day. Uterus was emptied and patient died in six hours.

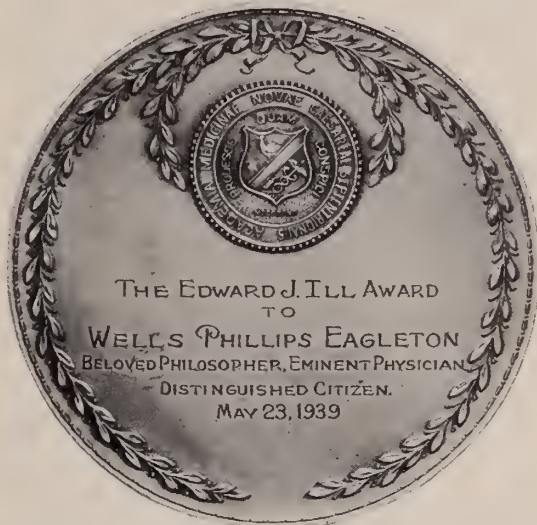
A. W. BINGHAM, M.D.

STATE SOCIETY ACTIVITIES

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY HONORS DR. EDWARD J. ILL AND DR. WELLS P. EAGLETON



Presenting the Award of Merit to Dr. W. P. Eagleton. From left to right are Dr. Charles M. Robbins, President-Elect of the Academy of Medicine; Dr. H. C. Barkhorn, President; Dr. Wells P. Eagleton, the honored member and guest; and Dr. Edward J. Ill.



The award of a bronze plaque presented to Dr. W. P. Eagleton

At the last meeting of Dr. Henry C. Barkhorn's administration as President of the Academy of Medicine, Dr. Edward J. Ill was made an honorary member and presented with a plaque as "First President, Benefactor and Honorary Member". Dr. Eagleton made the presentation, having spoken most thrillingly of Dr. Ill's significance to the community as a physician and a citizen. Dr. Charles M. Robbins, President-Elect, then showed pictures of Dr. Ill throughout his career, emphasizing his hospital connections and showing the development of local hospitals, through these many years of service. Fittingly enough, this meeting was held on May 23, 1939, the 85th birthday of Dr. Ill.

To climax the evening, Dr. Wells P. Eagleton was presented with the first Edward J. Ill

award, citing him as "Beloved Philosopher, Eminent Physician, and Distinguished Citizen". This award, established at the April meeting as a perpetual honor to Dr. Ill, shall be given, at such times as the Council deems wise, to that doctor from Northern New Jersey who merits it for his extraordinary service as a physician and as a citizen.

In presenting the plaque to Dr. Eagleton, Dr. Barkhorn spoke of the joy it gave him to honor his foremost mentor and guide, saying:

"His effort in season and out, through example and precept, to keep the medical profession moored to its high calling, his tremendous energy in stimulating and encouraging the spark of idealism, show how much we need him as a staunch warrior to battle on behalf of the profession in these troublous times."

SECOND FALL CLINICAL CONFERENCE

The second Fall Clinical Conference of The Medical Society of New Jersey will be held on November 9 and 10, 1939. Plans for the event are now being developed, sponsored by the Medical Society of Hudson County. The assemblies will be held in the hospitals of the county, and the demonstrations will be given by the attending physicians and surgeons. Details of the plans will be announced in The Journals of September and October.

THE NEW DIRECTORY

A new directory of the physicians of New York, New Jersey, and Connecticut will be issued late in the year, under the auspices of The Medical Society of New York. The Medical Society of New Jersey is coöperating by collecting and correcting the data regarding its own members.

Each physician who is listed in the last directory will receive a reply postal card to which there is attached a copy of his personal record as it appeared in the last issue of the directory—that of 1937.

Those physicians whose names are not in the last directory will receive a blank card asking for information on the following points:

Address—City, county
Full name

Home address, and office address
Office hours
Office telephone number
Medical college, and year of graduation
Date of N. J. license
Year of county registration
Society memberships—National, State, Special
Present Hospital Appointments
Present Dispensary Appointments.

It is to the advantage of every physician in New Jersey to supply the personal data regarding himself, and to submit it in the very near future.

A doctor whose name is not in the directory will probably be passed over when an official board, such as the Board of Workmen's Compensation, searches the list for the name of a physician to do special work in a locality.

LOAN MATERIAL ON MEDICAL ECONOMICS

By JOSEPH H. KLER, M.D., Chairman, Committee on Public Relations

One of the projects for the new administrative year of the Committee on Public Relations is making available to physicians information on medical economics. This is a popular topic for public discussion of peculiar importance. In order for physicians to discuss the subject intelligently, they must first inform themselves about it.

Copies of a speakers' service bulletin (No. 19) on "Medical Economics Policies of The Medical Society of New Jersey" have been distributed to the secretaries of county medical societies. Physicians may obtain a copy of

this bulletin either by writing to the secretary of their county medical society secretary, or by communicating with the Chairman of the Committee on Public Relations.

A package loan collection of publications on medical economics is now available from the committee.

A series of articles on medical economics has been prepared for the Passaic County Medical Society which are to be published in the bulletin of that Society. Editors of other county medical society bulletins may secure copies of the articles for publication.

THE CHIROPRACTIC BILL

The following circular letter has been sent to the president of each county medical society:

We are calling your attention to the fact that the vicious chiropractic bill, Senate 205, was passed last night in the Senate, and will require vigorous opposition in the Assembly. If this bill is passed, all of the provisions in A-210 tending toward uniform requirements for practitioners of the healing arts would be rendered impotent.

The following Senators have voted both for A-210 and S-205—though these bills are contradictory:

Senator Robert C. Hendrickson
Senator Charles E. Loizeaux
Senator Clifford R. Powell
Senator Haydn Proctor
Senator I. Grant Scott

If S-205 should, by chance, pass the Assembly and be signed by the Governor, our long, hard fight for A-210 will have accomplished little. Communicate with your Assemblymen at once and warn them of the dangers inherent in the chiropractic bill, S-205. This bill gives the chiropractors a separate board having complete control, and removes this control from the State Board of Medical Examiners.

THE Y. M. C. A. HEALTH WEEK IN JERSEY CITY

Young Men's Christian Associations throughout New Jersey conducted a "Health Week" from March 26th through April first. Each local Y. M. C. A. unit was responsible for the program within its community. One of the most effective of the community programs was that which was presented in Jersey City. The Hudson County Medical Society and the Jersey City Health Department participated actively to make this program a striking success.

Lectures on popular health subjects were delivered by physicians and other speakers to members of the Jersey City Young Men's Christian Association and their guests. The total combined attendance at these lectures was 866.

Several of the lectures were followed by performance of the preventive medical services which had been described in the lectures. A total number of 387 persons received diagnostic examinations, including tuberculin tests and Wassermanns.

In addition to the actual tests, the educational work in *public relations* was especially effective, because it gave the members of the Young Men's Christian Association a greater appreciation of its county medical society. In addition, the program resulted in several persons seeking the attention of private physicians and private dentists for services they needed. In helping these youths, physicians and dentists were also helping themselves.

THE MEDICAL LIBRARY ASSOCIATION

The forty-first meeting of the Medical Library Association was held in Newark, N. J., June 27-29, 1939, with the Academy of Medicine of Northern New Jersey as the hosts. There were 115 members in attendance, representing twenty-five states and Canada, and eighty-four institutions.

The program consisted of formal papers and discussions, and a trip of inspection to the Veterans Administration Facility in Lyons, New Jersey, and to Station WJZ, and the short-wave station at Bound Brook.

Addresses of welcome were given by Dr. H. C. Barkhorn, President of the Academy, and Miss Winsor, Librarian of Newark Public Library.

Dr. George H. Lathrope, President, Board of Trustees of the Morristown Public Library, gave an address on the subject "Why Medical History for Medical Librarians?"

Dr. Karl Scott, Chief of Venereal Disease Bureau, State Department of Health, gave an address on "The Literature of Syphilis".

Dr. Joseph E. Raycroft, Professor Emeritus, Department of Health and Physical Education, Princeton University, gave an address on "Old Wine in New Bottles".

"Problems in Microphotography" were illustrated by Miss Dorothy Hale Litchfield and Dr. Mary A. Bennett, Film Library, Columbia University. A demonstration was given of the method of photographing a whole page of a journal on a film the size of an ordinary moving picture frame; and also of the magnifying apparatus by which the film could be read with the ease of reading an ordinary book. The process has been developed by the United States Government, and the service is available commercially at a fraction of the cost of a book. Another advantage is the small amount of space required for storing the articles. The process is being expanded, and is already available in the larger medical libraries.

The Newark meeting was a successful demonstration of the broad scope and the high class of work done at the Newark Academy.

TALKING MOTION PICTURE ON SYPHILIS

Dr. J. Lynn Mahaffey, Director, the New Jersey State Department of Health, announces that a talking motion picture on "The Diagnosis and Treatment of Syphilis" has been prepared by the American Medical Association and the United States Public Health Service especially for the medical profession. It runs about ninety minutes, and shows in detail the modern methods of diagnosis and treatment

of syphilis as demonstrated by Drs. John Stokes, J. E. Moore, and other well-known authorities.

Any county medical society, hospital staff, or other medical group may obtain the use of the picture by applying to the State Department of Health, Trenton, N. J. The picture will be sent with an operator, projector, and screen, and no charge will be made.

PROGRAM OF THE COMMITTEE ON PHARMACEUTICAL PROBLEMS

By CHESTER I. ULMER, M.D., Chairman, Gibbstown, N. J.

The Advisory Committee on Pharmaceutical Problems announces the following objectives of its program of work during the current year:

1. To acquaint physicians with the New Jersey Formulary, and its ethical formulas. Its frequent use will overcome the tendency to write prescriptions for certain proprietary preparations. Many physicians prescribe overpriced, brand-controlled proprietary products.

2. To consider methods for eliminating some of the patent-medicine ballyhoo over the radio. We have already sent copies of a reso-

lution to the broadcasting companies. "Protesting against the prescribing of medicines and the giving of medical advice on the radio, with the exception of such broadcasts on health matters as are given under the auspices of recognized associations of licensed physicians or Federal, State, and Local Health Departments."

3. To maintain and improve the ethical and friendly relationships between physicians and pharmacists. The closely woven interests of the two professions require harmonious co-operation and mutual understanding.

LETTER FROM HON. ROBERT C. HENDRICKSON

The following letter from Hon. Robert C. Hendrickson, of Woodbury, President of the Senate, to President Carrington expresses his friendly attitude toward the physicians of New Jersey, particularly in regard to Assembly Bill 210. The letter is dated June 8, 1939, and is published with the Senator's permission.

I read with considerable interest the Society's objections to the proposed amendment to Assembly Bill 210, and although I know the basic reasoning which prompted your opposition to the amendment, the amplification of that reasoning as set forth in your letter is most enlightening and therefore quite helpful.

I trust it is needless for me to advise you that

I expect to support Assembly Bill 210 in its present form when it reaches the floor of the Senate, even as I have given it my support up to the present time, as is evidenced by the fact that I was willing to assign it to a friendly committee. It is primarily because I believe in the integrity of the profession that I am willing to risk the dangers which I see hidden in certain of the provisions of the bill.

I am quite certain that your representatives in Gloucester County made this fact known to you early in the session. My hope is that the medical profession continues to function down through the years to come on the same high plane which has marked its progress during the past decade, so that I will never have cause to regret the fact that I was willing to assume the risk.

HOUSEWIFELY PHYSIC

Dr. Franklin H. Church, of Salem, has discovered the following verses written by Thomas Tusser, an English farmer who was born about the year 1523. The author wrote the verses about the year 1560, and published them for the benefit of housewives. They are adapted to public health nurses of the present day in giving homely advice during their visitations.

HOUSEWIFELY PHYSIC. 1550

"Good huswife provides, ere a sickness do come,
Of sundry good things in her house to have some.
Good aqua composita, and vinegar tart,
Rose-water and treacle, to comfort thine heart.
Cold herbs in her garden, for agues that burn,
That over-strong heat to good temper may turn.
White endive and succory, with spinach enow;

All such with good pot-herbs, should follow the plough.

Get water of fumitory, liver to cool,
And others the like, or else lie like a fool.
Conserves of barbary, quinces and such,
With syrups, that easeth the sickly so much.
Ask Medicus' counsel, ere medecine ye take,
And honor that man for necessity's sake.
Though thousands hate physic, because of the cost,
Yet thousands it helpeth, that else should be lost.
Good broth and good keeping, do much now and then;

Good diet with wisdom, best comforteth man.
In health, to be stirring shall profit thee best;
In sickness, hate trouble; seek quiet and rest.
Remember thy soul; let no fancy prevail;
Make ready to God-ward; let faith never quail:
The sooner thyself submittest to God,
The sooner he ceaseth to scourge with his rod."

THE A. M. A. WINS ITS FIRST DEFENSE ACTION

The newspapers of Thursday morning, July 27, carried the news that the American Medical Association had won a favorable decision in the first step of its defense against the Federal indictment that had been found against it on December 20, 1938. The action is described in this Journal of January, 1939, pages 48-50.

The indictment had charged the A. M. A. with a violation of Section 3 of the Sherman Anti-trust Act. The A. M. A. and other defendants had brought a demurrer in the United States District Court, and Justice James M. Proctor had upheld it.

According to the Standard Dictionary, a demurrer is "A pleading that admits the facts stated in the pleading to which it replies, but denies that they are sufficient to constitute a good cause of action or defense in law."

1. THE NEWS ITEM IN THE NEW YORK TRIBUNE

An excellent description of the legal decision was contained in the news columns of the New York Herald Tribune of July 27, and was as follows:

Organized medicine won a major victory in District Court today, when Justice James M. Proctor approved demurrers to an indictment, returned last December, charging four medical organizations and twenty-one individual physicians with violation of the anti-trust laws. The indictment, a New Deal victory, had been unique in the annals of medicine. Its upset, it was announced, will bring an early appeal. Because of technical considerations, the Department had not decided tonight whether it could appeal the case directly to the United States Supreme Court or would have to take it to an intermediate court. The department also was studying the advisability of seeking a new indictment in a different form.

Today's decision was the first victory of importance won by organized medicine in the involved litigation in which the government charged the physicians and organizations with restraint of trade against Group Health Association., which was organized here by the Home Owners' Loan Corporation; certain of its member physicians, and various Washington hospitals. Justice Proctor's decision was based on the contention that medical practice was not a trade within the scope of the Sherman Act.

Wendell Berge, Special Assistant to the Attorney General, announced the probable intention to appeal in the absence of Thurman Arnold, Assistant Attorney General.

"I can't imagine we would let a question of this importance stand on a District Court decision," he said.

The indictment was the result of ten weeks of investigation by the Department of Justice. Homer Cummings, then Attorney General, announced at

the time that there was no charge of monopoly against doctors and groups, including the American Medical Association and some of its members, which fought medical coöperatives.

The government, he said, then complained of "unlawful restraints of trade, of efforts to coerce and boycott, efforts carried to the extent of refusing consultations and closing the doors of hospitals to physicians of approved professional qualifications". The indictment's main contention was that medical practice was a trade, and efforts to forbid physicians to join coöperative groups, or to close hospitals to patient-members of such groups, was a violation of the Sherman Act.

An argument of the defendants had been directed against the constitutionality of the Sherman Act, but with this Justice Proctor was not in accord. He previously had aided the cause of the American Medical Association when, before the returning of the indictment, he had reduced the scope of a subpoena against its records because he felt it unreasonable and oppressive. His twelve-page decision handed down today was founded largely upon his belief that medical practice was no trade.

He had a sharp rebuff for portions of the indictment which he said smack of "highly-colored, argumentative discourse", and others which he characterized as "vague and uncertain statements".

At the same time he disagreed with the contention of the defendants that the Group Health Association, an organization of government workers, was operating illegally in the field of medicine and insurance.

"I do not think it can be said from the bare allegations of the indictment that the association is engaged in medical practice or insurance," he said. "It is described as a non-profit, coöperative society organized under District of Columbia laws and engaged in the business of arranging for provision of medical care and hospitalization to its members and their dependents on a risk-sharing basis, which is enough to indicate that it was organized under those sections of the general corporation laws providing for incorporation of societies for benevolent, charitable, educational, literary, musical, scientific or missionary purposes, including societies formed for mutual improvement or promotion of the arts."

The defendant groups, other than the American Medical Association, were the District of Columbia Medical Society, the Harris County Medical Society, Houston, Tex., and the Washington Academy of Surgery.

The individuals, members of the A. M. A., were: Dr. Morris Fishbein, editor of "The Journal of the American Medical Association"; Dr. Olin West, Secretary and General Manager; Dr. William Creighton Woodward, Director of the Bureau of Legal Medicine and Legislation; Dr. William Dick Cutter, Secretary of the Council on Medical Education and Hospitals; and Dr. Roscoe Genung Leland, Director of the Bureau of Medical Economics.

Members of the District of Columbia Society were Dr. Arthur Carlisle Christie, Dr. Coursen

Baxter Conklin, Dr. James Bayard Gregg Custis, Dr. Thomas Allen Groover, Dr. Robert Arthur Hooe, Dr. Leon Alphonse Martel, Dr. Thomas Ernest Mattingly, Dr. Francis Xavier McGovern, Dr. Thomas Edwin Neill, Dr. Edward Hiram Reede, Dr. William Mercer Sprigg, Dr. William Joseph Stanton, Dr. John Ogle Warfield, Jr., Dr. Prentiss Willson, Dr. Wallace Mason Yater, and Dr. Joseph Rogers Young.

Seth W. Richardson, counsel for the A. M. A., issued a statement after the announcement of Justice Proctor's decision in which he explained that he always had believed that the opening of criminal proceedings against physicians and medical groups had been unwise and premature.

"The manifest current strategy of coercing citizens through the lash of criminal indictment—always easy for prosecutors to obtain from a grand jury—ought to receive a much-needed rebuke from Justice Proctor's decision," he said.

"If, as seems likely, the matter is to be reviewed by the Appellate Court, the country will thus have a belated establishment of what the law is, and to what it is applicable, which might well have preceded the much publicized institution of criminal proceeding."

2. THE TRIBUNE'S EDITORIAL COMMENT

On Friday, the New York Herald Tribune printed the following editorial entitled "Not a Trade", which is a most excellent commentary on the latest phase of the legal proceedings against the A. M. A.:

Judge Proctor's basic point in his decision for the American Medical Association and allied defendants in the anti-trust action against them—namely, that the practice of medicine is not a trade in the meaning of the Sherman law—seems to us thoroughly sound both as law and as social policy. If the medical profession is not a learned profession then there is no such animal, and if our statutes aimed at the restraint of trade are not to discriminate between trade and the learned professions, then the attempts of the latter to create standards of admis-

sion and service must sooner or later go by the board.

On the other hand, this does not mean that a professional association is always right or just either in its interpretation of its code or in the measures of enforcement it takes. Judge Proctor's decision does not settle the question whether the defendants acted in a high-handed and indefensible manner toward the physicians in Washington engaged in group practice for the benefit of Federal employees. An association, it will be remembered, was formed among employees of the Home Owners Loan Corporation to cooperate in providing medical care for its members and their dependents, engaging doctors for the purpose on a prepayment basis. The government contends that, prompted by officers of the American Medical Association, the local medical bodies instituted an active boycott against the experiment; that hospitals were closed to the cooperative's staff, that members of this staff who were also members of the local medical societies were either expelled or forced to resign their salaried positions on the staff; that specialists were forbidden to consult with those who remained, and so on. To all of which the defendants replied in substance that whatever discipline had been adopted was in pursuance of their right and duty to maintain the standards and ethics of the profession. Aware of the highly conservative tendencies of the A. M. A. and its local affiliates, and particularly of their traditional opposition to "socialized" medicine, the public would like to know whether the government's charges are true, and, if so, whether the acts complained of had real justification as a means of preventing malpractice or were provoked by prejudice.

We thoroughly agree with Judge Proctor that a criminal suit under the anti-trust laws is not a proper method of bringing this out. He has suggested civil action by the aggrieved parties. Meanwhile, it should occur to the A. M. A. and its host of friends and sympathizers that even the appearance of a boycott in defense of political and social theories is something which in this country should be avoided like the plague.

BOOK REVIEWS

Books are an essential part of the tools with which a physician works. The book reviews in this Journal are designed to be constructive. They are original in some features,—seldom in new discoveries, more frequently in analyses, and always in relationships to other subjects in the broad field of medicine. They are guides to every practitioner, not only as to the books which he should buy for frequent reference, but also as to those which he should peruse in the reading room of the medical library.

THE COMPLETE PEDIATRICIAN, Second Completely Rewritten Edition, by Wilburt C. Davison, M.A., D.Sc., M.D. 160 pages; 14 pages of index, and 30 pages of index to literature. Published by Duke University Press of Durham, N. C. 1938.

This practical manual of diagnostic, therapeutic and preventive pediatrics fills a great need for the use of medical students, internes, general practitioners, and pediatricians. It contains essentially all the material usually printed in a series of vol-

umes on pediatrics, but is actually condensed into a handbook of but $\frac{5}{8}$ -inch thickness. This has not been done by curtailing in any way the information included, but by an ingenious abandonment of literary style and substitution of indexing and cross-indexing of the facts somewhat like Roget's Thesaurus of the English Language. Pictorial illustrations have been completely eliminated to accomplish the condensation.

While the information seems at first disconnected,

one soon learns to follow the instructions in the preface of *The Compleat Pediatrician*, using the reference numbers rapidly to find a diagnosis or therapeutic suggestion or preventive factor. In developing the art of arriving at a correct diagnosis, this book is useful in the meticulous collection of evidence from every available source, and recalling all the conditions which may account for the symptoms.

The small size of this book makes it fit in the doctor's medical bag, and many pediatricians frankly acknowledge that they refer to it as an aid to clear thinking.

The author has used a whimsical adaptation of the title page of *The Compleat Angler* by Izaak Walton, 1653, for the title page of this book, and the reviewer believes he is justified in his use of the word "compleat" to indicate perfection. There is, however, no suggestion of the archaic beyond the title page.

D. E. O.

MEDICAL WRITING, THE TECHNIC AND THE ART. By Morris Fishbein, with the assistance of Jewel F. Whelan. Price \$1.50. Pp. 212. Chicago, A. M. A. Press, 1938.

A very complete handbook on all phases of the art of preparing a manuscript for publication. Every doctor who aspires to the publication of even one case report would find it worth while to purchase this book, read it over carefully, and keep it on his desk for ready reference. The bibliographical abbreviations are especially invaluable.

M. V. N.

MECHANISM OF THOUGHT, IMAGERY, AND HALLUCINATION. By Joshua Rosett, Professor of Neurology, Columbia University, New York City, 1939. Columbia University Press. \$3.

While physicians like Karel, and psychiatrists like Freud, increasingly stress the intangible, even perhaps the *spiritual*, aspects of human feeling and thinking, Rosett adheres to a rigidly *mechanical* explanation of behavior. In the present volume he offers a mechanistic explanation for thought, emotion, and hallucination. Thought, he interprets as a subjective reproduction of objective experience in which orientation in the past is guided by orientation in the present. As orientation in the present diminishes, the subjective experience becomes more vivid until it approaches imagery rather than thought; and as present sensory experiences are cut off, it merges into hallucination.

Intelligence is thus seen as a mathematical product of receptivity to stimuli on one hand, and the internal relations of memory parts on the other. As sensory alertness diminishes, the subject becomes disoriented in the present; subjective reproductions of past experiences, unsupervised by the surroundings, become both more vivid and less accurate. This is the essence of imagery. When receptivity to external stimuli is completely in abeyance, the productions of disorganized memory generate hallucinations.

How can we explain hallucinations following injury to the sensory cerebral area involved? The usual explanation in terms of irritation of contiguous association fibers is rejected by the author, who points out that hallucinations *do* occur in states of attention when no such injury is present. He suggests that if the reflex chain is interrupted, the advance neurone, cut off from the control of its previous neurone, exhibits release of function by producing hallucinations.

Consciousness is created by a state of attention which means that the channel between the mind and the barrage of outside stimuli must remain open. Emotions are only the *bodily changes* resulting from *sensory reactions*. These emotions and their generating sensory stimuli produce the conscious state.

On the matter of will—the rock on which many another theory of human mentality has been wrecked,—Rosett offers a totally mechanical explanation: the will is made up of the impulses, flowing from the store-house of past experiences, into the motor cells which eventually innervate the muscles. Thus a slave who picks cotton because of the whip of the overseer does not exercise "will" but is merely responding to a painful present sensory stimulus. The hired man who picks the cotton is activated by the distant goal of spending the money which he will receive for his work; this in turn flows from that store-house of past experiences in which is preserved memory of previous salary payments, and previous experiences with the value of money. Since industry has progressed more under voluntary labor than under chattel slavery, the volitional drive is obviously more efficient than the direct, simple sensory-motor reflex.

This smoothly written volume offers a firm base for students of human psychology who have been confused by the necessity of evaluating the imponderables. It is a backward-looking thesis in the sense that it is blind to anything unseen by the eye or the microscope in the sense that it lacks the humility which most modern psychologists feel in the face of the potency of spiritual and as yet unknowable forces. It is a forward-looking volume in the sense that it is impatient with superstitions, intolerant of reasoning in a vacuum, and insistent on the universal application of the scientific method.

HENRY A. DAVIDSON,
Newark, N. J.

ANATOMY OF THE HUMAN LYMPHATIC SYSTEM. By H. Rouvière, Professor of Anatomy at the Medical Faculty of Paris, France. A compendium translated from the original *Anatomie des Lymphatiques de l'Homme* and rearranged for the use of students and practitioners by M. J. Tobias, Assistant Radiologist, Montefiore Hospital, New York City. \$4.00. Ann Arbor, Michigan, Edwards Bros. 1938.

By making Prof. Rouvière's work on the human lymphatic system available to the English-reading and speaking anatomists and physicians, Dr. Tobias and Edward Brothers have rendered a service. There has been a dearth of English material on

this subject and the inadequacy of the information in standard anatomical texts and surgical anatomies is made quite apparent by a reading of this work. The addition of a few more schematic diagrams of various regions of the body would be helpful in correlating the intercommunications into readily assimilable form.

The publishers are to be commended on presenting such material at modest cost to the medical profession.

C. A. BELING.

IMMUNITY, PRINCIPLES AND APPLICATION IN MEDICINE AND PUBLIC HEALTH. By Hans Zinsser, M.D.; John F. Enders, Ph. D., and LeRoy D. Fothergill, M.D. Fifth edition of "Resistance to Infectious Diseases". Pp. 801. Macmillan Company, New York, 1939.

In preparing this excellent textbook, the fifth edition of Zinsser's "Resistance to Infectious Diseases", the authors found it necessary to rewrite and modernize it by incorporating the notable advances made in both the theoretical and clinical aspects of this increasingly important branch of medicine. The result—an entirely new book with the new title, "Immunity, Principles and Application in Medicine and Public Health"—is based upon the idea that in the present training of physicians "the barriers which until very recently separated the experimental laboratories from the clinics are gradually disappearing".

The book is composed of two distinct sections. The first part deals with the theoretical and experimental aspects of immunity. The latter part is devoted to the practical and clinical aspects of immunity in syphilis, tuberculosis, diphtheria, infections by the anaerobic group of organisms, diphtheria, scarlet fever, and other infections caused by the hemolytic streptococci, meningitis, pneumonia, typhoid fever, dysentery, whooping cough, plague, tularemia measles, poliomyelitis, rabies, and yellow fever.

While much of the theoretical chapters on antigens toxins, nature of antibodies, and complement may be somewhat involved for the clinician, other sections such as that on the basis of immunity, blood groups, and the various manifestations of hypersensitiveness in man will prove to be very stimulating to him.

Undoubtedly the latter part of the book has so much practical value and merit that it should have a wide appeal to the physician who wishes to be up-to-date in specific prophylaxis and therapy of virus and bacterial diseases. It is gratifying to read the authors' condemnation of the use of the various polyvalent streptococcal anti-bacterial sera for puerperal sepsis, septicemia, and erysipelas on the ground that no serum could be so polyvalent as to include all of the twenty-seven serological types, any one of which may be the etiologic agent in any of the numerous diseases caused by the streptococcus. Four pages are devoted to the therapy of streptococcal infections by sulfanilamide and related compounds.

The reader will also find a discussion of the comparative value of the different vaccines for whooping cough; the uses of the various immunizing agents in diphtheria; and the entire pneumonia story with the thirty types and the recent use of rabbit antipneumococcus serum. In each case the practical methods of standardization of the several toxins, antitoxins, and antibacterial sera are given.

Finally, the book is very well indexed, each chapter having its own thorough bibliography. The physical appearance of the printed page is made more attractive by the large type.

PHILIP LEVINE, M.D.

PRIESTS OF LUCINA, by Palmer Findley, M.D., F.A.C.S., Omaha. Price \$5.00. 421 pp. illus. Boston, Little, Brown and Co.

Dr. Findley calls his work "The Story of Obstetrics", and Professor Irving says in his foreword that it presents that story for the first time in English.

Like a skillful artist, the author paints the story of obstetrics in bold, lucid strokes, so that its outlines are clear, and the individual characters are real; yet he avoids too great detail lest the eye weary and lose the main theme; and invests the background with just enough suggestion of the history of medicine to provide necessary relief.

Thus, in the first of two parts in which the book is divided, after a brief review of primitive and ancient practices, the reader is carried forward through the centuries, the principle vehicle of his progress being the succession of brief, clear biographies of the significant contributors to the slow upbuilding of modern obstetric science.

This series of sketches starts with Hippocrates and ends with our own incomparable Williams. It is a satisfaction that in arranging the proper balance of national sources of these biographies, our own country receives its valid share.

The second part is devoted to the particular history of special phases of obstetrics; like the first part, introduced by a general topic, the history of anatomy; proceeding to consider the forceps, puerperal fever and Caesarean section. Here also is included discussion of a generally ignored topic, the history of the midwife. Findley rightly says, " * * * We must accord her a place of distinction. * * * In the hovels of the poor and in the palaces of the rich, * * * she "has literally held the destinies of the nations in" her "hands."

Finally there is a large and uniquely arranged bibliography.

To you who in imagination delight to walk in step with the great ones of other times; who are honest enough to wonder if *you* would have been equal, under the same circumstances, to anything like their achievements; and are humble enough to thank God that you are privileged to "stand on the shoulders of our predecessors", "The Priests of Lucina" is commended as an enjoyable, authentic and informative book.

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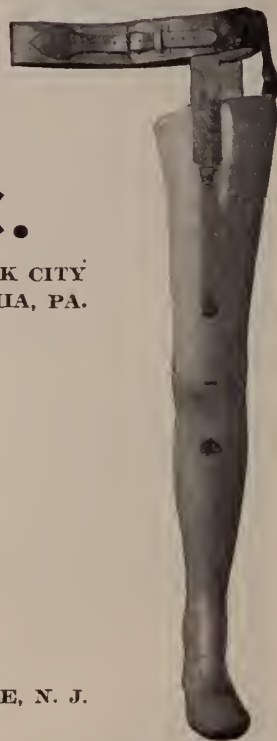
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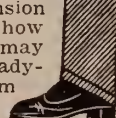
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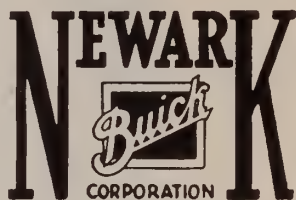
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Meetings at Trenton at 2:00 p. m. on October 1; December 3; February 18; April 14

HILTON S. READ, <i>Chairman</i>	Ventnor
E. ZEH HAWKES, <i>Ex-Officio</i>	Newark
ALFRED STAHL, <i>Ex-Officio</i>	Newark
WATSON B. MORRIS, <i>Ex-Officio</i>	Springfield
DAVID B. ALLMAN	Atlantic City
REEVE L. BALLINGER	Jersey City
G. BARTON BARLOW	Englewood
C. HARTLEY BERRY	Summit
FRANK A. BIEN	Irvington
ARTHUR W. BINGHAM	East Orange
C. BYRON BLAISDELL	Long Branch
F. CLYDE BOWERS	Mendham
WENDELL J. BURKETT	Pitman
NORMAN W. BURRITT	Summit
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WILLIAM J. CARRINGTON	Atlantic City
HARRY N. COMANDO	Newark
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FRANK L. FIELD	Far Hills
GEORGE W. FITHIAN	Perth Amboy
J. IRVING FORT	Newark
BARCLAY S. FUHRMANN	Flemington
GEORGE B. GERMAN	Camden
DAVID W. GREEN	Salem
D. LEO HAGGERTY	Trenton
DONALD O. HAMBLIN	Bound Brook
HENRY HAYWOOD	New Brunswick
EUGENE HERBENER	Lakewood
WILLIAM G. HERRMAN	Asbury Park
ERNEST G. HUMMEL	Camden
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ABRAHAM E. JAFFIN	Jersey City
SIGURD W. JOHNSEN	Passaic

THOMAS M. KAIN	Camden
JOSEPH H. KLER	New Brunswick
FREDERIC W. LATHROP	Plainfield
JULIUS LEVY	Newark
CHARLES LITWIN	Teaneck
JOSEPH F. LONDRIGAN	Hoboken
WRIGHT MACMILLAN	Passaic
JACOB J. MANN	Perth Amboy
WILLIAM W. MAVER	Jersey City
CHARLES H. MITCHELL	Trenton
JOSEPH R. MORROW	Ridgewood
HERSCHEL S. MURPHY	Roselle
LESLIE E. MYATT	Bridgeton
STANLEY NICHOLS	Long Branch
BERTHOLD S. POLLAK	Jersey City
FREDERIC J. QUIGLEY	Union City
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TRAUGOTT J. SCHUCK	Hoboken
REUBEN S. SHARP	Camden
BYRON G. SHERMAN	Morristown
SPENCER T. SNEDECOR	Hackensack
JAMES H. SPENCER, JR.	Franklin
S. EMLEN STOKES	Moorestown
ADOLPH TOWBIN	Lakewood
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CHESTER I. ULMER	Gibbstown
H. ROY VAN NESS	Newark
WILLIAM H. VARNEY	Washington
H. BURTON WALKER	Vineland
CLARENCE W. WAY	Sea Isle City
WILLIAM C. WILENTZ	Perth Amboy
J. ALLEN YAGER	Paterson
A. CHARLES ZEHNDER	Newark

SUB-COMMITTEES OF THE WELFARE COMMITTEE

Meetings at Trenton at 11:00 a. m. on October 1; December 3; February 18; April 14

Legislation

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WILLIAM C. WILENTZ Perth Amboy
CHARLES H. MITCHELL Trenton
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FREDERIC J. QUIGLEY Union City
ROBERT E. WATKINS Belmar
THOMAS E. MANLY Paterson
JOSEPH M. KUDER Mount Holly
SAMUEL ALEXANDER, *Consultant* Park Ridge

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HARRY N. COMANDO Newark
GEORGE W. FITHIAN Perth Amboy
SPENCER T. SNEDECOR Hackensack
CHESTER I. ULMER Gibbstown
REUBEN L. SHARP Camden
J. IRVING FORT Newark
SIGURD W. JOHNSEN Passaic
A. CHARLES ZEHNDER Newark
THOMAS K. LEWIS, *Consultant* Camden

Public Health

STANLEY NICHOLS, *Chairman* Long Branch
FREDERIC W. LATHROP, *Vice-Chairman* Plainfield
ABRAHAM E. JAFFIN Jersey City
ARTHUR W. BINGHAM East Orange
FREDERICK G. DILGER Hackensack
JULIUS LEVY Newark
HENRY B. ORTON Newark
ELBERT S. SHERMAN Newark
C. BYRON BLAISDELL Long Branch
ERNEST G. HUMMEL Camden
ALLEN G. IRELAND Trenton
HERSCHEL S. MURPHY Roselle
MILLARD F. SEWALL Bridgeton
THOMAS M. KAIN Camden
WATSON B. MORRIS, *Consultant* Springfield

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J. ALLEN YAGER, *Vice-Chairman* Paterson
G. BARTON BARLOW Englewood
EDGAR P. CARDWELL Newark
JOSEPH R. MORROW Ridgewood
LAWRENCE H. BLOOM Phillipsburg
WATSON B. MORRIS, *Consultant* Springfield

ADVISORY COMMITTEES TO PUBLIC HEALTH SUB-COMMITTEE

Meetings at the call of the Chairmen

Adult Health Supervision

HERSCHEL S. MURPHY, *Chairman* Roselle
WILLIAM H. VARNEY, *Vice-Chairman* Washington
EDWIN G. DEWIS Interlaken
EDWARD C. KLEIN, JR. Newark
RALPH K. HOLLINSHED, *Consultant* Westville

Cancer Control

HENRY B. ORTON, *Chairman* Newark
WILLIAM G. HERRMAN, *Vice-Chairman* Asbury Park
JOHN B. FAISON Jersey City
CHARLES B. WOODMAN Morristown
AUGUSTUS S. KNIGHT Far Hills
WILLIAM A. ANTOPOL Newark
JOSEPH H. KLER New Brunswick
OTTO R. HOLTERS Asbury Park
THOMAS J. SUMMEY Moorestown
FLOYD E. KEIR Englewood
ANTHONY J. DELARIO Paterson
THOMAS B. LEE, *Consultant* Camden

Child Health

STANLEY NICHOLS, *Chairman* Long Branch
WALTER B. STEWART, *Vice-Chairman* Atlantic City
ARTHUR F. ACKERMAN Summit
ERNEST G. HUMMEL Camden
IRVING OKIN Passaic
L. CHARLES ROSENBERG Newark
CHESTER R. BROWN Arlington
ALDRICH C. CROWE, *Consultant* Ocean City

Conservation of Vision

ELBERT S. SHERMAN, *Chairman* Newark
CHARLES H. SCHLICHTER Elizabeth
JOSEPH H. KLER New Brunswick
HALVOR L. HARLEY Atlantic City
WALLACE PYLE Jersey City

Conservation of Vision—Continued

ENOCH BLACKWELL Trenton
GEORGE J. HOLMES Newark
JAMES S. SHIPMAN Camden
RAYNOLD N. BERKE Hackensack
ELIAS J. MARSH, *Consultant* Paterson

Crippled Children

ELMER P. WEIGEL, *Chairman* Plainfield
FREDERICK G. DILGER, *Vice-Chairman* Hackensack
LEOPOLD SZERLIP Newark
TOUFFICK NICOLA Montclair
OSWALD R. CARLANDER Merchantville
SETH B. SPRAGUE Jersey City

Maternal Welfare

ARTHUR W. BINGHAM, *Chairman* East Orange
J. CARLISLE BROWN, *Vice-Chairman* Atlantic City
SAMUEL A. COSGROVE Jersey City
GEORGE B. GERMAN Camden
CARL H. ILL Newark
JULIUS LEVY Newark
ROBERT A. MACKENZIE Asbury Park
WALTER B. MOUNT Montclair
J. HARRIS UNDERWOOD Woodbury
HARRISON B. WILSON Hackensack
HAMMELL P. SHIPPS Delanco
THOMAS B. LEE, *Consultant* Camden

Pneumonia Control

THOMAS M. KAIN, *Chairman* Camden
FRED VOSBURGH Passaic
CHARLES F. RATHGEBER East Orange
CLAUDIO E. MCNENNEY Jersey City
THOMAS K. LEWIS, *Consultant* Camden

Tuberculosis

ABRAHAM E. JAFFIN, <i>Chairman</i>	Jersey City
SAMUEL B. ENGLISH, <i>Vice-Chairman</i>	Glen Gardner
NORMAN W. BURRITT	Summit
LEO B. DRAKE	Franklin
CLYDE M. FISH	Pleasantville
MARCUS W. NEWCOMB	Browns Mills
HAROLD S. HATCH	Morristown
JOHN E. RUNNELLS	Scotch Plains
H. BURTON WALKER	Vineland
JOSEPH R. MORROW	Ridgewood
HENRY B. KESSLER, <i>Technical Adviser</i> , representing Com- missioner J. J. Toohey, Department of Labor	Newark
ROY GRIFFITH, <i>Technical Adviser</i> , representing Manu- facturers' Association of New Jersey	Glen Ridge
GEORGE J. YOUNG, <i>Consultant</i>	Morristown

Traffic Accidents

MILLARD F. SEWALL, <i>Chairman</i>	Bridgeton
THOMAS S. P. FITCH	Plainfield
CHRISTIAN P. SEGARD	Leonia
GEORGE J. YOUNG	Morristown
J. LYNN MAHAFFEY	Haddonfield
ARNOLD VEY, <i>Technical Adviser</i> , representing A. W. Magee, Commissioner of Motor Vehicles	Trenton
ELIAS J. MARSH, <i>Consultant</i>	Paterson

Venereal Disease

C. BYRON BLAISDELL, <i>Chairman</i>	Long Branch
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MARSHALL D. HOGAN	Boonton
BAXTER A. LIVENGOD	Swedesboro
FRANCIS J. MCCAULEY	Newark
HYMAN J. UDINSKY	Passaic
KARL M. SCOTT	Atlantic City
ARTHUR J. CASSELMAN, <i>Technical Adviser</i>	Camden
WILLIAM F. COSTELLO, <i>Consultant</i>	Dover

ADVISORY COMMITTEES TO MEDICAL PRACTICE SUB-COMMITTEE**Meetings at the call of the Chairmen****Auxiliary Medical Services**

SIGURD W. JOHNSEN, <i>Chairman</i>	Passaic
SAMUEL BARBASH, <i>Vice-Chairman</i>	Atlantic City
ARTURO R. CASILLI	Elizabeth
EUGENE G. HERBENER	Lakewood
JEROME H. SAMUEL	Newark
WALTER A. TAYLOR	Trenton
ALFRED STAHL, <i>Consultant</i>	Newark

Contract Practice

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HENRY HAYWOOD	New Brunswick
HARVEY T. HEROLD	Newark
EDWARD F. KLEIN	Perth Amboy
ANDREW C. RUOFF	Union City
J. HOWARD HORNBERGER, <i>Consultant</i>	Roebling

Hospital Relationships

SPENCER T. SNEDECOR, <i>Chairman</i>	Hackensack
WILLIAM H. A. WARNER, <i>Vice-Chairman</i>	East Orange
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GEORGE O'HANLON	Jersey City
CHARLES HYMAN	Atlantic City
EARL H. SNAVELY	Newark
THOMAS K. LEWIS, <i>Consultant</i>	Camden

Industrial Health and Hygiene

J. IRVING FORT, <i>Chairman</i>	Newark
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CHARLES LITWIN	Teaneck
JAMES H. SPENCER, JR.	Franklin
RALPH D. VREELAND	Newark
DONALD O. HAMBLIN	Bound Brook
WILLIAM F. COSTELLO, <i>Consultant</i>	Dover

Medical Care of the Indigent and Low-Wage Group

GEORGE W. FITHIAN, <i>Chairman</i>	Perth Amboy
DAVID W. GREEN, <i>Vice-Chairman</i>	Salem
FRANK L. FIELD	Far Hills
D. LEO HAGGERTY	Trenton
BYRON G. SHERMAN	Morristown
HENRY C. BARKHORN	Newark
WILBUR WATTS	Trenton
THOMAS A. CLAY	Paterson
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VICTOR KNAPP	Asbury Park
HARRY SUBIN	Atlantic City
THOMAS J. WALSH	Elizabeth
H. WESLEY JACK	Camden
FRANK L. PERRY	Woodstown
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Pharmaceutical Problems

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MERWIN L. HUMMEL	Merchantville
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DANIEL W. TELLER, JR.	Morristown
RALPH K. HOLLINSHEAD, <i>Consultant</i>	Westville

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JOSEPH F. LONDRIGAN, <i>Vice-Chairman</i>	Hoboken
WILLIAM K. HARRYMAN	Hackensack
JOHN H. IRWIN	Englewood
HENRY H. KESSLER	Newark
FREDERICK W. SHAFER	Camden
DANIEL F. FEATHERSTON	Asbury Park
CEDRIC C. CARPENTER	Summit
ANDREW F. MCBRIDE, <i>Consultant</i>	Paterson
STEPHEN LORENZ, <i>Technical Adviser</i> , New Jersey Depart- ment of Labor	Trenton

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DAVID H. B. ULMER	Moorestown
JAMES F. NORTON, <i>Consultant</i>	Jersey City

Ways and Means

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SPENCER T. SNEDECOR	Hackensack
CHARLES H. SCHLICHTER	Elizabeth
WATSON B. MORRIS	Springfield
WELLS P. EAGLETON	Newark

Study of Eugenic Sterilization

WRIGHT MACMILLAN, <i>Chairman</i>	Passaic
S. EMLEN STOKES	Moorestown
WALTER J. FARR	Teaneck
THEODORE R. ROBIE	East Orange
JOHN F. CONDON	Newark
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FRANK J. McLOUGHLIN	Jersey City
WILLIAM A. DWYER	Paterson
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First Vice-President, MRS. FRANK P. NICHOLSON..Jersey City
Second Vice-President, MRS. O. R. CARLANDER..Merchantville

Recording Secretary, MRS. BANKS BAKERCamden
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OCEAN	J. Edwin Obert, New Egypt	Harry S. Ivory, Point Pleasant... Tel. 212	L. Roberto Carmona, Tuckerton
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SUSSEX	James H. Spencer, Franklin	A. H. Groeschel, Sussex	Edward K. Hawke, Newton
UNION	Rowland P. Blythe, Cranford	Lorrimer B. Armstrong, Westfield. Tel. 0077	C. C. Carpenter, Summit
WARREN	Wallace R. Bostwick, Blairstown.	N. C. Marlett, Belvidere	H. B. Bossard, Phillipsburg

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BURLINGTON	F. D. Fahrenbruch	Mount Holly	237
CAMDEN	Edmund Hessert	Collingswood	607
CAPE MAY	Clarence W. Way	Sea Isle City	55
CUMBERLAND	J. S. Knowles	Millville	52
ESSEX	Alfred Muerlin	158 S. Harrison St., East Orange	Orange 5-9026
GLOUCESTER	Chester I. Ulmer	Gibbstown	Paulsboro 18
HUDSON	Joseph P. Donnelly	1 Madison Ave., Jersey City	Delaware 3-6682
HUNTERDON	P. W. Baker	High Bridge	170-R-2
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MIDDLESEX	Charles H. Calvin	80 Commerce St., Perth Amboy	4-0941
MONMOUTH	William Heatley	Red Bank	80
MORRIS	George L. Nicoll	Dover	180
OCEAN	George W. Gaumer	422 First St., Lakewood	81
PASSAIC	Theodore K. Graham	279 Park Ave., Paterson	Sherwood 2-9422 and 1607
SALEM	William G. Hilliard	Salem	332
SOMERSET	Samuel H. Pogoloff	Manville	Somerville 1228
SUSSEX	H. M. Aitken	Ogdensburg	Franklin 2002
UNION	Arthur E. Tator	57 DeForest Ave., Summit	6-0313
UNION (Colored)	C. DeFreitas	423 W. Fourth St., Plainfield	6-5332



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easily and quickly, without interruption
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Whether S.M.A. is prepared in New York or California, or even enroute, the feedings are always uniform—like breast milk.

In any climate, S.M.A. remains fresh and sweet, because it is nitrogen packed to prevent oxidation or change in its chemical and physical composition.

INFANTS RELISH S.M.A. — DIGEST IT EASILY — THRIVE ON IT!

S.M.A. is a food for infants — derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride;



altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and in physical properties.

"Look for the Name GOLDEN GUERNSEY and the Trade Mark."



A Suggestion for the Diet of Convalescents

There is an unusually large quantity of fat and milk solids in Golden Guernsey Milk. That alone is sufficient recommendation to many physicians when they're treating cases of undernourishment or convalescence. But in addition, the appealing flavor and attractive color of Golden Guernsey are known to be welcome by such patients whose appetites for milk often need stimulating.

There is no other milk exactly like Golden Guernsey—in flavor, food-values, or color. Its deep yellow results from an abundance of carotene, a primary source of vitamin A.

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Producer for Supreme Milk &
Cream Co.
Visitors Welcome

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Lipoiodine Tablets, "Ciba" exert satisfactory iodine effects in selected cases of hyperthyroidism, pre- and post-operatively. Given in small doses, Lipoiodine is slowly eliminated for sustained iodine influence with reduced risk of iodism. Tasteless. Little

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Lipoiodine* Tablets (organic iodine content 41%) also find clinical usefulness in secondary and tertiary syphilis, bronchial affections, arteriosclerosis, scrofulosis, etc. . . . Supplied in bottles of 30 and 100 tablets (4½ grs. each).



L I T E R A T U R E U P O N R E Q U E S T

*Trade Mark Reg. U. S. Pat Off.
The word "Lipoiodine" identifies
the product as ethyl ester of di-
iodobrassicic acid

CIBA PHARMACEUTICAL PRODUCTS, Inc.
SUMMIT, NEW JERSEY



CANNED FOODS AND HUMAN ENERGY REQUIREMENTS

● An adequate supply of food energy is one of a number of nutrient requirements of man. Fortunately, all nutrients—with the exception of water, minerals and accessory factors—supply chemical energy which the body can utilize to support muscular activity and life processes. Individual foods will, however, vary in the extent to which they supply food energy.

The energy requirements of man and the caloric values of foods have long been fields of active investigation. Energy requirements are measured in terms of a heat unit, the calorie. Many researches (1) show that human caloric requirements are variable and influenced by a number of factors.

During periods such as infancy, childhood, pregnancy and lactation, or during convalescence from wasting illness, energy-yielding nutrients are required both for support of body activity and for tissue formation. However, for the average adult, food energy intake should balance energy expenditure. For adults, variation in activity is the chief factor influencing variation in energy requirement; age, sex, size and body build being comparable. Sedentary occupations may require a food energy intake of 2500 calories per day; 5000 calories might be necessary if the individual engaged in strenuous muscular activity. Close approximations are available for the probable food energy requirements of individuals during different stages of the life cycle and engaged in various activities (1, 2).

Experiments (3) have also demonstrated that oxidation of foodstuffs in the animal body—due allowance being made for the energy contents of the end-products of oxidation—yields the same number of cal-

ories as are produced by the oxidation of similar foodstuffs in the combustion type calorimeter. Since the potential food energy of foodstuffs resides in their contents of carbohydrates, fats and proteins, the available calorific value of any food may be readily calculated (4) by using the factors 4, 9 and 4 calories per gram of these respective nutrients. Of these food components, the carbohydrates and fats are those which contribute most towards attainment of our varied, food energy requirements. Reliable tables are available (5) which list the calorific contributions of most common foods.

It has been established first, that foods—principally by virtue of their carbohydrate and fat contents—contribute energy for use by the human body; and second, that the human energy requirement is conditioned by many factors and may vary widely. An adequate supply of food energy is, of course, one of the necessary objectives of proper nutrition. However, individual attributes such as vitality, strength or endurance are influenced by—but not solely dependent on—proper nutrition, in which adequate food energy is supplied.

The food energy values of commercially canned foods are essentially those of the raw materials from which they are prepared. In some instances, the natural caloric values of the raw foods may have been enhanced by the medium in which they were packed, for example, carbohydrate-bearing syrups or sauces used in the canning procedure. Consequently, since canned foods include products of both high and low caloric intakes, such foods are valuable in formulating diets to supply any intake of food energy which might be desired.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

1. 1938. Nutrition Abstracts and Review. 7, 509.
2. 1933. U. S. Dept. Agr. Circular No. 296.
3. 1931. The Elements of the Science of Nutrition, Fourth Edition, Graham Lusk, Saunders Co., Philadelphia, pp. 61-74.
4. 1938. Chemistry of Food and Nutrition, Fifth

- Edition, Henry C. Sherman, Macmillan Co., New York, pp. 150.
5. 1931. U. S. Dept. Agr. Circular No. 146.
1931. U. S. Dept. Agr. Circular No. 50.
1935. Dietetics for the Clinician, Second Edition, M. A. Bridges, Lea & Febiger, Philadelphia.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the fifty-first in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

HAY FEVER RELIEF

Weeks of acute misery, or weeks of comparative comfort? To the hay fever sufferer 'Benedrine Inhaler' often makes just that difference.



Case History: (W. L.) Physician, male, white, age 39. Being allergic to ragweed, patient submitted to inhalations of this pollen to induce an acute attack of hay fever for purposes of observation.

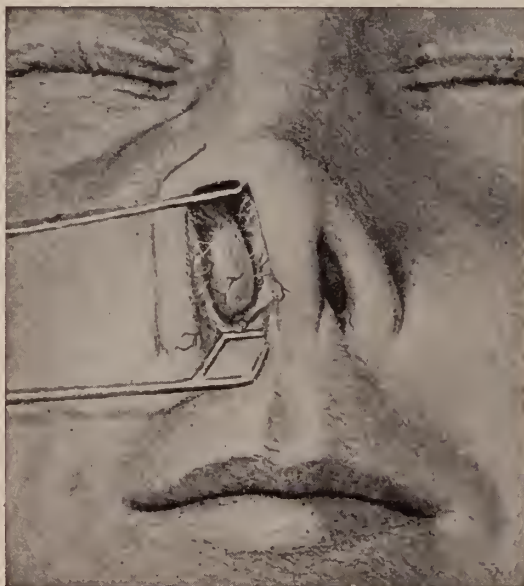


Fig. 1 — 1:45 P. M. Before treatment. Note extreme venous stasis and edema.

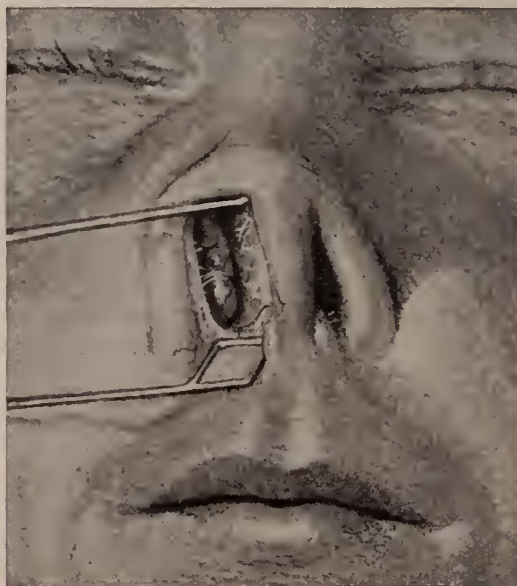


Fig. 2 — 2:07 P. M. After treatment with 'Benedrine Inhaler'. Complete shrinkage and blanching.

Each tube is packed with amphetamine, S. K. F., 0.325 Gm.; oil of lavender, 0.097 Gm.; menthol, 0.032 Gm. 'Benedrine' is S. K. F.'s trademark, Reg. U.S. Pat. Off., for their nasal inhaler and for their brand of amphetamine.



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Pylorospasm.
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3. Q. What makes Karo safe bacteriologically?
A. *Karo is heated to 165° F. and poured into pre-heated cans and vapor vacuum-sealed for bacterial safety.*
4. Q. What is a goat's milk formula for the newborn?
A. *Evaporated goat's milk, 6 ozs. Boiled water, 12 ozs. Karo Syrup, 2 tablespoons.*
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The complete findings of this test were published under the title, "The Therapeutic Application of Acidophilus Milk in Constipation of Children," appearing in the *American Journal of Digestive Diseases*, Vol. 5, pp. 170-173, May, 1938.

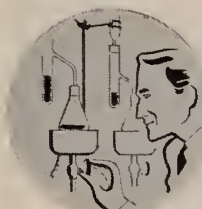
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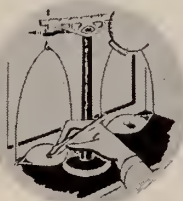


1 ASSAY OF MATERIALS—Ingredients for soft elastic capsules, like all other raw materials, are first subjected to assay.

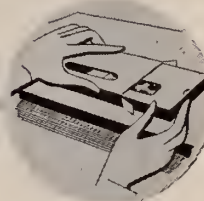
2 CAPSULATION—The fluid, between gelatin sheets, is sealed into uniform capsules by tons of pressure exerted by this press on the capsule forms.



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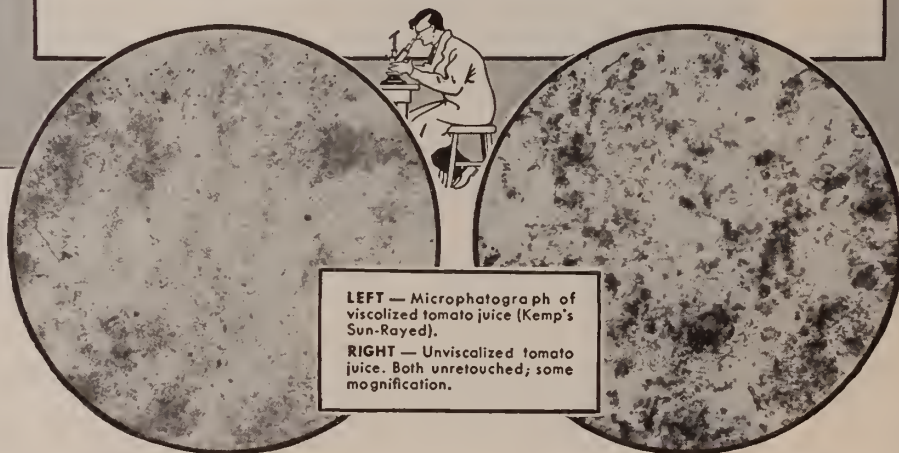
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RIGHT — Unviscolized tomato juice. Both unretouched; some magnification.

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The common toxic effects of this drug are now well recognized. Disturbance of renal function is one of the most important complications, hematuria having been noted with considerable frequency. Hemolytic anemias similar to those seen in patients treated with Sulfanilamide also occur.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY

UNDER THE
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COMMITTEE ON PUBLICATION



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EDITORIAL

Governor's Conference on Health and Welfare

A Committee on Health and Welfare was appointed by Governor A. Harry Moore last Fall, in order to suggest a program for the State of New Jersey to follow in its relations to the Federal security laws and policies. The committee was composed of officers from the State Department of Institutions and Agencies representing the welfare groups, and officials of the State Department of Health and The Medical Society of New Jersey representing the medical groups. The organization meeting of the general committee was held on November 16, 1938, as described in this Journal of December, 1938, page 751.

The members of the several sub-committees devoted themselves diligently to their work; and on June 7, Dr. Kler, Chairman of the Sub-Committee on Public Relations, summarized the work of the Governor's Committee in a report to the House of Delegates. The Reference Committee expressed its opinion of the work of the Governor's Committee as follows:

This coöperative movement to bring together governmental and medical agencies for a practical survey of health problems in the State of New Jersey is far in advance of that in other sections of the country. * * * It is our conclusion:

First, that the wise attitude of Governor Moore in creating the Committee for the Study of Public health is fully recognized by our profession.

Secondly, the general committee and the various sub-committees have done a very valuable service to this Society, and to the State, and deserve our utmost thanks for their great contribution to this problem.

The House of Delegates voted its unanimous agreement with these opinions.

The Executive Committee of the Governor's Conference met on Friday, September first, to discuss the final form of its report. The reports of many of the sub-committees, including that on public health, were submitted in writing, ready for publication. It is expected that the entire report will be ready for distribution in the late Fall, and, if possible, will be issued as a supplement to The Journal.

Fall Clinical Conference

Both the desirability and the success of the newly established Fall Clinical Conference last Fall have led the House of Delegates and the Trustees to hold another Conference this Fall, in the hope and expectation that it will be an annual event. The Hudson County Medical Society has offered to be host to the members of The Medical Society of New Jersey, and to provide a two-day program consisting of a series of events, both scientific and social, that will appeal to every physician.

The dates of the conference will be November 9 and 10, when the members have settled down to their routine practice after their Summer vacation, and are ready to apply their instruction and inspiration to their daily practice at once.

Jersey City, in which the meeting will be held, is peculiarly well adapted to the medical conference, for practically every phase of medical practice is exemplified in its "Medical Center"; but the smaller hospitals will also be recognized and their work demonstrated.

A conference, medical or popular, is often an unbalanced affair, with a large outflow of ideas from a very few leaders, and a meager return current from passive listeners to the lecturers. This Fall's Conference, like that of last year, will consist of a flow of ideas in a closed circuit in which the responses of the hearers will equal the conceptions of the speakers, transformed into power and action, and augmented by accessions from the listeners.

The program of the conference will be announced in the October Journal.

Administrative Medicine

A classic example of a patient-doctor relationship is the Biblical story of Naaman, written in the days of Jeshosaphat, King of Judah, 900 years before Christ, and recorded in the Second Book of Kings, chapter five. Naaman, a high general in the Syrian Army, had a serious skin disease which was diagnosed as leprosy. He consulted the prophet-doctor Elisha, expecting to receive a spectacular treatment without effort on his part, and felt himself insulted when he found that the prescription was a daily bath in the muddy waters of the Jordan River. An essential character in the story is a young Hebrew maid who was the first public health nurse and who persuaded Naaman to carry out the doctor's prescription whereby he was cured. The story closes with a tale of attempted graft, which has a familiar sound.

Read the story of Naaman and apply it to conditions in the present day.

IS HEALTH RECEIVED OR ACHIEVED?

A major problem in modern therapeutics is that of inspiring patients to follow the direc-

tions of their medical advisers. About one-half of all patients are Naamans, who expect to receive health from a bottle of medicine, as they are told over the radio a dozen times a day. A doctor often excuses his failure to effect a cure by asserting that the patient is unwilling or unable to carry out his directions because of indolence, or prejudice, or impatience, or poverty, or some other personal condition. If the patient remains sick in body or mind, the doctor is usually blamed because there is no prescription that will compel the patient to practice either self-denial, or active hygienic procedures.

FACTORS IN MEDICAL SERVICE

Three factors must always be considered in providing medical service to a sick person:

1. The doctor with his skill in diagnosing and treating diseased conditions of both the body and the mind.

2. The community in providing the means for bringing medical services within reach of every patient according to the needs which he cannot supply by his own resources.

3. The patient himself in his coöperation varying from complete rest, repose, and relaxation, to active effort both mental and physical.

THE FIRST FACTOR,—THE DOCTOR IN PRIVATE PRACTICE

A fundamental principle in medical service is that of the responsibility of the individual doctor for the correctness of his diagnosis and treatment of every individual patient whom he accepts. The laws of New Jersey and other states do not recognize the practice of medicine by corporations or other groups, but only that by individuals. Even in hospitals and departments of health the individual physician or technician is responsible for the correctness of the diagnoses which he makes, the tests which he applies, and the treatments which he administers. But his employment by a department of health or other governmental agency does not protect a doctor against his neglect to apply the tests and treatments which are recognized as standard. If a suit is brought for improper practice, it must be against the doctor who did the improper act or neglected an essential procedure.

The county medical society is essential to every private practitioner in order to establish standards of diagnosis and treatment, and principles of ethical relationships of physicians to one another and to their patients, and the public generally. The medical society is a continuing school for the instruction of its members; a bureau of information regarding the efficiency of medical services; and a court for enforcing the high standards of the practice of medicine.

Membership and activity in the medical society is the best evidence of a doctor's conformity to the highest standards of medical practice.

THE SECOND FACTOR,—THE COMMUNITY

The duty of the community "To promote the general welfare" of its citizens is written in the preamble to the Constitution of the United States of America. In accordance with this provision the governments of the nation and

the several states have recognized sickness as a major menace to the general welfare. They have enacted laws requiring that parents shall provide medical services for their dependent children, and employers of labor shall care for their injured workmen; and schools shall supervise the health of their pupils. When the Emergency Relief Administration was established in New Jersey in 1933, medical service for the sick poor was added to the three fundamental needs,—food, clothing, and shelter. Under this provision about seven per cent of the relief money was spent for ordinary medical services to persons and families on the relief rolls.

Medical science has developed to such an extent that many forms of service are not commonly available except in large medical centers. The assertion may be made, with a considerable degree of fairness, that over one-third of sick people are unable to secure *all* the services which the medical profession can render. The Federal Government proposes to establish a nation-wide system by which any person may secure any form of medical service which the profession can offer. This is a new proposition and no one can foresee its ramifications or the answers to the questions:

Who shall be entitled to receive the services?

What services shall be offered?

What shall be their extent and quality?

Will it lead to the destruction of individual initiative and the establishment of a great dependent class?

One principle of action is sure: The development of any great system of medical care is the function of the medical societies of the states and the nation.

The official medical society of the county, or the State, or the nation, is the medical adviser of the community, be it small or large.

The representatives of the medical societies constitute the group that is best qualified to establish an efficient system of governmental participation in the distribution of medical services to those who cannot obtain all its various

forms by their own resources. To do this requires each medical society to be the medical adviser of the official boards of its territory—the county medical society in the county; the State Medical Society in the State; and the American Medical Association in national affairs. This form of service may properly be called the practice of *administrative medicine*, in distinction from medical advice given by individual doctors to individual persons who employ them. The practice of administrative medicine is recognized as one of the major activities of The Medical Society of New Jersey, as is shown by the fact that in 1938, its Journal devoted 52 per cent of its pages to the medical activities of hospitals, nursing and welfare groups, government relief agencies, public schools, and similar organizations.

Only the active working members of medical societies can foresee and prevent the abuses which are sure to develop under any system of government control of medical services. Every practitioner of medicine therefore has a personal interest in the control of the practice of administrative medicine by the medical profession. New Jersey is an outstanding leader among the states in this form of medical practice, as is demonstrated by the acceptance of The Medical Society of New Jersey as the official adviser to the State Department of Health in the expenditure of Federal health funds that are allocated to the State. Every practitioner of medicine in the State should realize this fact, and do his part to continue the Medical Society in its position of leadership.

THE THIRD FACTOR,—THE PATIENT HIMSELF

The leaders of the "New Deal" in medicine, as in economics, are mistaken in their assumption that sick and "nervous" individuals will always make wise use of the medical services which would be offered to them under the proposed Federal law for medical relief. The tendency of the law will be to encourage the near-sick and the would-be ill to defer recovery in order to continue on the relief rolls. Every doctor is besieged with requests for certificates of ill-health as an excuse for avoiding work

and yet receiving wages while they are idle; and possibly additional money for relief.

Every doctor is often implored to prescribe medicine for mental and nervous states whose cause is not overwork in gainful pursuits, but indulgence in the pleasures and excitements of modern life.

Every doctor is aware of the abuse of his services by those who are unwilling to *achieve* health, but expect the doctor to transform the sick period into a prolonged vacation on full pay.

A half century ago the great problem of the medical profession was how to secure the participation of physicians in public health affairs, especially those relating to contagious diseases.

A decade ago there arose a movement for the participation of the *community* in the care of those sick persons who could not afford the newer and more expensive forms of medical service.

The next step that is needed is the development of means for detecting and correcting nervous and emotional states, such as those which impel strong men to continue on the relief rolls after a trifling illness, on the plea of delayed recovery.

The reaction of the sick toward their afflictions are at present unclassified and untreated. Some sick persons are of a heroic character and recover their working ability by strong will power, persistently applied.

Some are resigned to their condition and passively bear it with calmness.

Some pose as martyrs and bask in the sympathy which they arouse.

A large group, especially from lists of the employed, continue on the sick rolls because they profit by being "sick", while they complain of symptoms which do not belong to any known disease.

Will some neurologist organize a group of his fellows who will study the nervous and emotional conditions that are often associated with sickness, and will develop tests for their diagnosis and effective methods of their treatment? This will be necessary if the proposed Federal system of medical relief is to function successfully.

ORIGINAL ARTICLES

VALUE OF ROENTGEN THERAPY IN ACUTE SUBACROMIAL BURSITIS

By WILLIAM GETTIER HERRMAN, M.D., F.A.C.R., Asbury Park, N. J.

Read before the Section on Radiology at the Annual Meeting of The Medical Society of New Jersey,
June 7, 1939.

The purpose of this communication is not to bring to your attention again subacromial bursitis so ably ascribed by Codman in 1906-1912, nor to announce a new method of treatment for this condition, since this too is an old story. The first notation of x-ray therapy that I have run across goes back as far as 1924 when Fred Hodges, in reporting the treatment of carbuncles and other infections, made mention of having treated a case of subdeltoid bursitis, however without success. Dr. E. A. Merritt also treated such cases with beneficial results during the same year. It is our desire in this short article to point out the value of Roentgen therapy in the *acute* condition.

Many patients suffering from this disability will get well spontaneously; others, if not treated, will run into chronicity and may be more or less disabled for a number of years, or may have re-occurring exacerbations with comparative freedom between attacks. All types of treatment have been used with more or less success. Deposits when present have been removed surgically, injections of iron cacodylate and other chemical agents have been reported as giving relief from pain and causing disappearance of the deposit. Diathermy has been quite a favorite method of treatment, and the writer personally has successfully treated cases by this method. Immobilization in the acute stage, and stretching and breaking up of adhesions in the chronic stage, are also successful measures. However, there is no method that the author knows of that will bring such quick relief in the acute cases and cause such a quick disappearance of the deposit as Roentgen therapy. It, therefore, seems worth while, for a few minutes, to focus your

attention on a subject with which most of you are no doubt already familiar.

Codman, in his original quotation, stated:

"It is not too much to assume that this bursa, like any other bursa in response to the insult of trauma, over-use, unaccustomed uses, following severe treatments or operation in that region, or infection, may become inflamed, may become over-distended with fluids, may be filled with fibrous exudate or its contiguous surfaces may become adherent."

Even since Codman's day there has been argument among authorities as to whether or not the pathology is in the bursa, or actually in the tendon of the supraspinatous muscle underlying the bursa. Codman himself first described the condition as involving the bursa, and today this form of disabled shoulder is often referred to as the "Codman shoulder". "Diagnostic Roentgenology", of which Ross Golden is editor, takes the opposite point of view, and does not even mention subacromial bursitis in his index, but refers to this condition as calcification in the supraspinatous tendon. A case of his was operated upon and the deposit found in the outer part of the supraspinatous tendon. This material proved to consist of about 20 per cent calcium carbonate, and 80 per cent calcium phosphate. From our standpoint it makes little difference whether the inflammation is in the underlying tendon, or the overlying bursa.

The cause of the inflammation and the deposit has not as yet been definitely ascertained. It probably can arise from a variety of causes. Injury has very definitely been proven to be a cause, but many cases give no history of any definite trauma. Unaccustomed use of the shoulder, strain or sprain or occupations which

cause one to hold the arm in such a position that the tendon is under strain or the bursa is pinched, may give rise to the train of symptoms accompanying this disturbance. The "pitcher's glass arm", the "orchestra leader's paralysis", and the painful shoulder occurring in dentists, are examples of this occupational causation. In other cases, focal infection and metabolic disturbances have been considered the etiology.

For purposes of treatment we may divide our cases into three classes: acute, subacute, and chronic. The acute case generally has symptoms arising suddenly, with severe pain in and about the shoulder, acute tenderness just below the acromial process, and pain radiating to the neck and down the arm even to the fingertips—in other words, spreading along the brachial plexus distribution. Elevation and rotation of the humerus is limited and painful.

In the subacute stage, the symptoms are similar in some cases. In others the patient is merely conscious of discomfort on motion with weakness of the biceps or complains of muscular pain in the biceps.

In the chronic case there is apt to be some limitation of motion, but without much pain except when the arm is elevated to right angles with the body, or having been raised over the head is again brought down to a point of right angles. In the chronic case there is probably considerably thickening of the bursa or tendon sheath, together with adhesions; and with the arm in the position mentioned, this thickened tissue may be pinched between the acromion process and the greater tuberosity of the humerus.

In passing it must be mentioned, of course, that before considering pain and disability referred to the shoulder joint as being due to subacromial bursitis or calcification in the supraspinatous tendon, other conditions must be ruled out. If there is a history of trauma, we must rule out by history, physical examination and x-ray, tuberculosis, lues, osteomyelitis, and bone tumors. Where an x-ray of the shoulder joint is negative for bone or joint pathology, and reveals a semi calcareous deposit which may be either minute or almost

as big as the acromion process, the diagnosis is fairly easy. But it must be remembered that there are some cases without deposit in the acute stage, and chronic cases where the deposit has undergone resorption, and only adhesions and thickened membranes remain.

Our series of cases is quite short, being only ten. For purposes of brevity we have brought to you today a record of seven cases, three acute, two subacute, and two chronic.

CASE 1, ACUTE

Mr. U.—This patient's brother, a doctor in New York City, referred him for therapy within three days after the onset of acute symptoms. This was his first attack and not an exacerbation of a subacute or chronic condition. He brought with him his x-ray showing a large deposit. His pain was so acute that he could not sleep at night without morphine, and he could not get his arm in any comfortable position during the daytime. We gave him four treatments directly over the deltoid muscle every other day, the dose being 106 r per treatment. The factors used were 190 kv., $\frac{1}{2}$ cu., 1 al. His first treatment was given on October 1st, his last treatment on October 8th, and an x-ray taken on October 11th showed the deposit had completely reabsorbed.

CASE 2, ACUTE

Mr. N.—This patient had a sudden attack of pain over the *anterior* aspect of the humerus directly after the hunting season. For about a week he tried home remedies, thinking that he had a sore muscle as a result of his gun "kicking too hard". He then went to see a physician, who had us radiograph his shoulder. We found deposits such as we have seen beneath the acromion process, but which were located, in this case, in the region of the latissimus dorsi tendon rather than the supraspinatous. His physician elected to try diathermy, but without success. We were able to persuade the attending physician to allow us to give x-ray therapy within about ten days of the onset of symptoms, and we gave this patient a series of four treatments every other day, averaging 108 r, using 150 kv., $\frac{1}{4}$ cu. and 1 al. filter. After four treatments the pain had disappeared although the arm was still somewhat stiff. A week after the last treatment the patient reported by telephone that he was entirely well. A subsequent x-ray taken two weeks after the first x-ray showed that the deposit had entirely disappeared and the patient was symptom-free.

CASE 3, ACUTE

Mr. C.—This patient was a butler in the family of one of my colleagues. About two weeks before Christmas he had an acute attack possibly brought on by the hanging of Christmas decorations, and the arm being held in upward extension and an unaccustomed position for too long a time. His arm was exquisitely painful and had to be immo-



Figure 1.—Case 3, Mr. C. Before Treatment

bilized in plaster to give him any comfort at all. We assured his employer and the patient that if we could be allowed to give him some treatment we would have him back on the premises helping to make Christmas cheer. With some skepticism on the part of the patient and physician we gave him four treatments of 105 r each over the shoulder cap, using 180 kv. and $\frac{1}{2}$ cu. These four treatments gave the patient complete relief. This pa-



Figure 2.—Case 3, Mr. C. Three Weeks After Treatment

tient has not had any relapse. These three acute cases illustrate the quick subsidence of symptoms, and a speedy absorption of the deposit. Dr. Latt-

man reports that he customarily uses 350 r with 200 kv. and that usually one treatment is sufficient. His cases have an aggravation following the treatment, but with the small doses we have been giving we have not had our patients experience reaction.

CASE 4, SUBACUTE

Mrs. M.—This patient came to us in July with a radiograph taken in the winter showing deposits beneath the acromion process of the right shoulder. She had some pain and tenderness, but neither was marked. The limitation of motion of the shoulder was marked, and there was weakness in the arm muscles. We gave her 100 r every other day for four doses using 150 kv., $\frac{1}{4}$ cu. and 1 al. Two weeks after the first treatment there was a 50 per cent reduction of the deposit. Two additional treatments were given with complete relief from symptoms.

By this time the left shoulder was giving her discomfort although this shoulder had never bothered her before. The left shoulder responded to the series of four treatments.

Later in the fall the patient had a recrudescence of symptoms in the right shoulder. A further series of treatments relieved her, and we have not heard from her since. We judge that she has had no further trouble since she told us that having tried several other forms of treatment before receiving x-ray treatment that she would return at once if she was bothered again.

CASE 5, SUBACUTE

Mrs. S.—Patient was five months' pregnant when she was sent to us for therapy, her physician being willing to try x-ray therapy rather than any other form of treatment because of her pregnant condition. She had had acute pain and tenderness for a number of weeks. We gave her the usual series of four treatments running from 104 to 112 r per treatment, 150 kv., $\frac{1}{4}$ cu., and 1 al. She was much relieved by the time of the last treatment. Ten days after the first treatment the deposit was 50 per cent gone but reexamination two weeks after this proved the deposit to be returning, and so were the symptoms. We then gave her a second series of two treatments, each averaging 186 r, using a higher voltage 180 kv., $\frac{1}{2}$ cu. She was completely relieved following the second series.

These two subacute cases, you will note, took additional therapy, while a single series relieved the three acute cases.

CASE 6, CHRONIC

Miss D.—This patient had had discomfort beneath the acromion process for several months. The symptoms were not acute. She complained of tiredness and an ache in her shoulder, with soreness in the biceps muscle and limitation of abduction and elevation of the arm. X-ray examination was positive for a deposit.

We gave her a series of four treatments every other day averaging 105 r, using 180 kv. and $\frac{1}{2}$ cu. She was improved by the time the last treatment was given so far as discomfort was concerned, but the motion of the arm was still limited. Three

CASE 7, CHRONIC

Mrs. S.—This patient had had symptoms of sub-acromial bursitis for about three years. We gave her a series of four treatments but in her case because of the chronicity a dosage of 150 r per treatment was given. This patient experienced some relief from discomfort; but like the preceding case, there was limitation of motion following the treatments. She promised to return for follow-up, but we have lost track of her. In our opinion, she will need what the last patient had, i. e., breaking up of adhesions.

In this short series it will be seen that the acute cases are quickly relieved of pain and discomfort, the deposit is absorbed, and full motion returns to the arm. The subacute cases need extra treatment and take considerable longer to respond; while the chronic cases will not be relieved entirely by x-ray therapy due, we believe, to the fact that inflammation has been present long enough to cause chronic changes in the tissue, thickening, induration, and adhesions.

Dr. Mangess, of Jefferson Medical College, before his death when speaking before the Medical Society, made the statement that he believed before long all forms of infection would be treated by x-ray. Our experience with bursitis merely parallels our experience with other forms of inflammatory reactions. In acute cases, the quicker we can get in our therapy the more spectacular are our results in relieving pain and causing subsidence of inflammation. We believe that, whatever may be the etiology and the pathogenesis of so-called subacromial bursitis, there is a definite inflammatory process present, and that the response to the x-ray therapy in this condition is very similar to that seen in acute infections.

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Figure 3.—Case 6, Miss D. Before Treatment

weeks after the treatment the deposit was seen to be reoccurring, and a second series of four treatments was given using 150 kv. and averaging 104 r. Two weeks after the last treatment of the second series the deposit was again less, but still present. We decided to wait two weeks longer. When we found that the deposit was still present we gave two treatments of double dosage. This time the deposit disappeared. The patient still had limitation of motion and we referred her to an orthopedic physician for breaking the adhesions and stretching the arm.



Figure 4—Case 6, Miss D. Three Weeks After Treatment

THE EYE IN DIABETES

By S. SCHULSINGER, M.D., Newark, N. J.

Read March 13, 1939, before Eye, Ear, Nose, and Throat Section of the Academy of Medicine of Northern New Jersey.

In diabetes the eye is subject to two fundamentally different types of change: (1) the chemical, and (2) the vascular. Disorders of the *anterior* part of the eye are usually more or less associated with *chemical* changes of the intraocular fluids, while alterations of the *posterior* part of the eye are more often the result of *vascular* changes. So in young diabetics we find disorders in the anterior part of the eye only; whereas we notice changes in the posterior region chiefly after the age of forty-five, when vascular pathology is more common.

The chemical composition of the aqueous humor varies with the chemistry of the blood. Its sugar content (which is somewhat lower than the sugar content of the blood plasma) increases with elevation of blood sugar, though not with the same rapidity. The lower sugar content in the aqueous humor has been explained by avid sugar adsorption of the lens. The acidity of the aqueous exceeds that of the blood, the aqueous being poorly equipped with buffer salts. In diabetic acidosis large quantities of acetone are found in the aqueous. In general, we find in the aqueous all the pathologic bodies circulating in the blood.

Altered chemistry of the intraocular fluids appears to be the basis for changes in the posterior layers of iris, for the changing refraction of the lens, and for the destructive changes within the lens leading to cataract. Some changes in the anterior part of the eye may also be caused by vascular pathology.

In the iris we find *hydropic degeneration* of the posterior pigment epithelium, a histologic change that may occasionally be seen with the slit lamp. It is described by Vogt and Metzger as "Thickened pupillary margin with a spongy surface perforated by many pores". According to Ascher, it is caused by relative hyperacidity of the aqueous humor, and is responsible for the "Black aqueous", sometimes seen during an intraocular operation. Due to impairment of the cellular walls of the pigment epithelial layer, the cells burst at the moment

of opening the eye, so that the aqueous becomes colored with the pigment discharged by the cells.

A vasculogenic condition of the iris is *rubeosis iridis*. This non-inflammatory process is characterized by the development of new vessels in the sphincter part of the iris. Investigations have also revealed new vessels and anterior synechiae in the angular part of the iris. This explains the occasional report of rubeosis iridis leading to glaucoma. In this instance it could be considered a diabetic glaucoma (Crocco).

The most frequent and important disorder, however, is the *diabetic iritis*, which, according to Crocco, occurs in about seven per cent of diabetics. It may be metastatic, or chronic. The metastatic form, which is usually acute, is due to a purulent focus in another part of the body. The chronic form, which is clinically not characteristic, often causes a secondary glaucoma.

In thinking of iris changes, one must remember the *insufficient action of atropine* in diabetics,—probably due to the sympathicotonia prevalent among diabetics. Another factor is the effect of insulin on the action of atropine. During an attack of iritis a temporary suspension of insulin will benefit the eye condition. Conflicting interests of internist and ophthalmologist in such cases demand close coöperation between the two physicians.

Changes in *pupillary reaction* rarely occur in diabetes.

Changes of *accommodation* (premature presbyopia) may be caused by general weakness of the muscles, or by changes in pigment epithelial cells on the posterior surface of the ciliary body similar to the changes described above on the iris.

Among lenticular changes, first is the rather frequent and sudden *alteration of refraction*. This usually brief change disappears with improvement in the general condition. It presents itself as myopisation, or hyperopisation

following the institution of treatment. An interesting illustration, provided by Elschmig, conclusively proves that the seat of this change is the lens. His patient had one aphakic eye. Only the eye *with* the lens underwent the refractive change, whereas the eye *without* the lens remained with the same refraction.

Granström believes that dehydration is the cause. We know of cases of myopisation in severe diarrhea where dehydration is prevalent. Other factors may include disturbance in the ciliary body, especially the cells from which the zonula originates, and the frequent nuclear sclerosis. This condition requires intensive general treatment to correct it in the shortest possible time. Rarely are we required to give corrective lenses unless the patient is excessively disturbed at work.

Rapid development of subcapsular *cataract* simultaneously in both eyes is usually diabetic. Only in these cases—and in younger patients—can one speak with some certainty of *diabetic cataract*. Beyond the age of forty, it is impossible to differentiate between diabetic and senile cataract, even with a slit lamp.

Typical diabetic cataract is rare, as fewer than one per cent of diabetics suffer from it. The age of the patients cited varies from eleven months, to forty years. However, diabetes seems to predispose to senile cataract as studies show a higher glycaemia and a lower glucose tolerance in cataract patients. O'Brien found 41.6 per cent among 238 cataract patients with a blood sugar over 120 mgm. per 100 cc.; and in 50 per cent of the patients a lower glucose tolerance. Langdon found reduced sugar tolerance in thirteen of seventeen patients. This phenomenon may also be explained by the premature senescence in diabetics.

The morphology of the diabetic cataract, as seen by the slit lamp, was first described by Schnyder. His patient, a thirty-three-year-old female, was negligent about coöperating in treatment for her diabetes. At the first examination he found massive subcapsular opacities anteriorly and posteriorly in the pupillary region of the lens, as well as in the periphery. They appeared like grayish clouds (floculi) in the anterior part of the lens, and more whitish and flat in the posterior part. In the larger

opaque areas one could distinguish droplets of fluid. The anterior opacities were subepithelial. The superficial markings of the lens fibers were distinctly visible. Occasional displacement of fibers resulted in lanciform intervals appearing as vacuoles. A few vacuoles were also found in the cortex.

At reëxamination a month later, the opacities became more transparent, some of them disappearing completely. The resulting large vacuoles united to form large gaps. The vacuoles between the fibers also became larger and deeper. A short time later complete blindness developed due to further confluence of the vacuoles, with resulting excessive swelling of the lens.

Most authors consider the disturbance of the osmotic balance as the immediate cause of diabetic cataract. Goldschmidt found a low PH (7.15 instead of 7.36) in the aqueous of diabetics. This impairs oxydation within the lens, especially the autoxydation of cystein to cystin. Other possible causes are disturbance of water balance, toxins and impairment of the ciliary body.

Under intensive treatment an early diabetic cataract will remain stationary or even regress. This makes it essential in early cataract to recognize its diabetic etiology if present, for prompt and adequate therapy may halt the progress of the lesion.

Surgical prognosis of diabetic cataract or of cataract in diabetics is good, especially since the introduction of insulin. The diabetic without acidosis, or much hyperglycemia, is scarcely more susceptible to infection than the average patient.

Diabetics are peculiarly susceptible to *blepharitis* and *hordeola*. There is also a form of *conjunctivitis* found in diabetics characterized by vascular changes around the limbus similar to the changes in rubeosis iridis. Occasionally we see corneal complications in form of *ulcer* or *deep keratitis*.

Hypotonia of the bulbus always occurs in diabetic coma. Importance of this sign to the internist is its reliability for the differential diagnosis between diabetic and other forms of coma. It is found even prior to the loss of consciousness; and serves, in such a case, as

warning of the impending coma. This diminished tension is apparently due to loss of water in the ocular tissue, especially the vitreous. With improvement of the basic condition, the tension returns to normal.

Even outside of the comatous stage there seems to be an interrelation between intraocular pressure and insulin as some investigators find an elevation of the intraocular tension after insulin injection. Thus Poos had a diabetic patient who on a daily dosage of 80-100 units of insulin still had a blood sugar of 250 to 300 mgm. By regulating the amount of insulin and thus the blood sugar level, he found that intraocular tension varied directly with the sugar level. At a blood sugar of 650 the tension was 13 mm.; at 300 the tension was 16 mm.; at 100 it was 21 mm.; and at 35 (pre-shock stage), the tension was 26 mm. Apparently retention or loss of water accounted for the change of the intraocular tension. It is like the findings in Phloridzin diabetes, where the increase in intraocular pressure parallels the retention of water. We can produce similar changes by promoting ingestion of large amounts of salt.

The eye condition most frequently met with in diabetes is *diabetic retinitis*. We find it usually in older persons with a long diabetic history; cases in young patients are exceptional. The general incidence of retinitis among diabetics is 16 per cent. Average age at which it appears is about fifty-seven. Duration of diabetes before onset of retinitis is seven or eight years. Remember also that the diabetic ages more quickly than the non-diabetic—(Senium praecox of Von Noorden). According to Shields Warren, "The diabetic has not only more than his share of arteriosclerosis, but it falls to his lot ten or twelve years earlier than to the non-diabetic!" These facts, and the prevalence of renovascular disorders in diabetics with retinitis, are strongly suggestive of a pathogenetic relation between the two states, although we are unfamiliar with the exact mechanism of this interrelation. However, diabetic retinitis is an entity by itself, showing a well-circumscribed ophthalmoscopic picture differing from arteriosclerotic or hypertensive retinitis, thus suggesting that some additional

factor is responsible for the diabetic retinitis. Safar sees the cause of diabetic retinitis in the changes of the vessels too small to be visible ophthalmoscopically. Others explain the characteristic bleeding and exudation by diapedesis from the vessels. Few histologic studies have been made as little autopsy material is available. At the time of post-mortem the diabetic changes are usually superseded by senile, sclerotic vascular changes. Reported findings include sclerosis and hyaline degeneration of the media in the large vessels; degeneration of the intima of the small vessels and capillaries; proliferation of the intima of the arterioles causing narrowing of their lumens.

Typical of diabetes was the finding of Stau-
pendahl, who described small hemorrhages at the posterior pole in the nerve-fiber layer and internuclear layer. Within the last layer he found homogenous white masses consisting mainly of coagulated albumen. Koyanagi also reports that the white patches represent a transudate rich in albumen almost devoid of fibrin. Deposits of glycogen were seen by Mori along the walls of the capillaries. Degeneration of nerve fibers and ganglion cells has often been described; but there is no edema, nor involvement of pigment epithelium nor implication of the choroid. Orlandini found, after extirpation of the pancreas in animals, retinal bleedings and degeneration of ganglion cells.

In the ophthalmoscopic picture hemorrhages are the principal feature. Besides the pin-point and striped hemorrhages (as in sclerosis) we find small circular or larger, sometimes quite extensive, hemorrhages sharply delimited within the deeper layers of the retina. Hemorrhages are localized around the posterior pole, but can also be found in the periphery. Emboli and thrombi in small vessels are often found as part of the sclerotic component of the picture. Very often exudative patches are seen around the macular region, occasionally arranged in a circinate manner. They are characterized by waxy appearance. There is no tendency to edema, and no cottonwool patches.

Many ophthalmologists feel that in retinitis and preretinal bleeding, insulin only aggravates the condition. Existence of haemorrhagic retinitis should tell the physician to rely less

upon insulin, and more on dietary and hygienic regulations.

Conservative treatment will not improve the retinitis; but it will not aggravate it. Diabetic retinitis has no consistent prognosis; but statistics indicate that 50 or 60 per cent of these patients die within three years.

Another pathologic picture is *lipemia retinalis*, which is caused by a high fat-content of the blood. Its outstanding characteristic is that the vessels are lighter in color, appearing almost as white stripes, making differentiation between veins and arteries impossible. It usually affects young males afflicted with lipemia. Lowest reported fat content was four per cent; commonest is between four to eight per cent. However, high fat content is not the only cause, as we never find this condition with other disorders combined with a high blood fat, such as jaundice, pregnancy or the acetonemic vomiting of children. Nor does the severity of the condition parallel the intensity of the blood-fat level. High blood acidity is also present in these cases. Insulin is very effective in treatment, and since the introduction of insulin the condition is becoming very rare.

Diabetics frequently suffer from *retrobulbar neuritis*. It occurs more often in males, commonly beyond the age of fifty, and is often unilateral. It may be caused by diabetes only, although tobacco and alcohol favor its appearance; and even moderate use of these toxins in diabetes may produce lesions in the optic nerve. In addition to the changes in the optic nerve,

we see lesions in the tract, geniculate body, and optic radiation causing various degrees of hemianopsia.

The prognosis, favorable in the early stage, especially with the use of insulin, is more serious in the advanced stage. This makes it important to recognize the condition early. It is chiefly because of retrobulbar neuritis that Lichtwitz has emphasized the importance of the control of the diabetic by the ophthalmologist. Remember, too, that unilateral scotomata may remain unnoticed for a long time by the patient, only to be discovered later by thorough ophthalmologic examination.

The frequently occurring disturbances of adaptation may be explained by chemical changes in the visual purple. They usually vary with the blood-sugar level.

Paralysis of muscles most frequently affect the abducens, less often the oculomotor, rarely the trochlear. These changes occur only in the presence of hypertension, and the diabetic etiology is questionable. The muscle affection is usually caused by a central lesion. Elschnig suggested that a brain lesion might be the primary affection causing both the diabetes and the muscle paralysis.

Sympatheticotonia in diabetics has already been discussed. To be mentioned in this connection is prolonged mydriasis after adrenalin instillation. Insulin increases the tone of the sphincter, which explains the diminished effect of atropine.

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HISTOLOGY OF RADIATION EFFECTS IN INFLAMMATORY CONDITIONS

By RAPHAEL POMERANZ, M.D., Newark, N. J.

The use of radiation in the treatment of inflammatory lesions has been known for a number of years. The basic work on this subject was laid down by Dunham, Pfahler, Hodges, and Manges in this country, and Heidenhain, Freid, Freund, Wintz, and others abroad.

While the rationale of the treatment has been established empirically, many phases of

it are still unknown. Clinical observations and experimental work have been used for the study and evaluation of this mode of treatment. Obviously the clinical observations are more numerous than histological studies because the majority of the lesions get well, and tissue studies are unavailable.

The fundamental concept of inflammation is that it is an elementary response or reaction

of the living cell to an injury or stimulus. This response or defense mechanism of the body is supplied by the reticulo-endothelial system. The response varies with the particular character, duration, and intensity of the stimulus, and the nature of the tissue undergoing stimulation in various organs and individuals. The response to a stimulus may be local or general, or both.

The essential factor of inflammation consists of increased permeability and electrical conductivity of the injured cell whereby substances can more freely enter the cell, or escape from it. It is obvious that the inflammations differ not only in duration and severity, but also in kind. While one irritant will produce a local hyperplasia of leucocytes, another will produce an exudate consisting in the main of mononuclear lymphocytes and macrophages. Such differences are of considerable therapeutic import in explaining the various radiation effects obtainable.

ACUTE INFLAMMATIONS

The histologic picture in an acute inflammation represents in the main an accumulation of lymphocytes, leucocytes, tissue edema, and vascular hyperemia. Experimental proof and clinical observations have shown that small doses of radiation cause primarily the destruction of the lymphocytes and leucocytes, which are the most sensitive cells. By the destruction of these cells, phagocytosis is enhanced; ferments, antibodies, and other unknown protein-like bodies are liberated which produce a general favorable effect. The rays have no direct bactericidal effect.

Peretz and others studied the serum of patients and animals inoculated with staphylococcus to determine the quantity of antibodies before and after Roentgen therapy. Their conclusions were that the favorable effect of Roentgen therapy lies in hyperaemia and improved lymph circulation, causing large quantities of antibodies to accumulate around the inflammatory focus, which in turn increases the phagocytosis.

INDICATIONS

Acute mastoiditis, furuncles, carbuncles, acute cervical adenitis, pneumonia, gas-bacillus infection, and others.

DOSAGE

The favorable radiation effect depends on the type and number of the accumulated cells. This varies with the virulence and type of the infecting agent, the bacteria, the localization and type of tissue, the type of the individual, and the stage of the disease. Outside of all these factors it will depend on the spacing of treatments and the doses applied, as well as the experience of the therapist.

After an initial increase of symptoms noted by swelling and rise of temperature, marked relief of pain will follow. The favorable effect results either in clearing of the debris, and diminution of edema, general improvement; or the treatment will accelerate the process of suppuration with the formation of a localized abscess, which is easily emptied by a small surgical incision. Following this the clinical course of the case will be shortened.

The principle in dosage should be that, the more acute an inflammatory process, the smaller should be the radiation dose applied. The initial dose begins now with 25-50 R units, which is much smaller than were used twenty to twenty-five years ago. The variations of dosage and technic will be discussed in specific instances by other members on this symposium.

CHRONIC INFLAMMATORY LESIONS

In chronic inflammatory lesions we find connective tissue changes to have progressed further, less leucocytes, and more lymphocytic infiltration. The radiation effect will again depend on the stage of activity of the R. E. cells. The connective tissue is less sensitive than the leucocytes, and will respond only to larger doses of radiation. In cases where the inflammation is obsolete and calcification has taken place, the radiation effect is unfavorable.

Indications: Chronic inflammatory soft structure lesions, tubercular adenitis, chronic bursitis and peritendonitis, sinusitis, asthma, and others.

Dosage: The dose used begins with about 100-125 R units. The intervals are usually longer. Specific instances will be discussed by other members on this symposium.

CYSTOCELE

By JOSHUA W. DAVIES, M.D., A.B., F.A.C.S., New York City

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Read before the Section on Obstetrics and Gynecology at the 173rd Annual Meeting of The Medical Society of New Jersey in Atlantic City, on June 8, 1939.

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"The Cystocele, Its Anatomical Disturbance and Reconstruction", S., G. and O., Sept., 1936, Vol. 63, pages 349-352.

"Urinary Stress Maintenance—The Anatomical Defect Found and a Rational Method for Its Treatment", S., G. and O., Sept., 1938, Vol. 67, pages 273-280.

"Abdominal and Pelvic Fascias, with Surgical Applications", S., G. and O., March, 1932, pages 495-504.

After witnessing the birth of a child, it is almost impossible to believe that such a large mass could pass through the comparatively small duct of the uterus to the exterior. But since it happens, the fact must be accepted as one of the wonders of nature, and the function of the mid-wife dims in importance to a very servile rôle. As time elapses and the demands of the child are no longer foremost in the mind of the mother, she may complain of a dragging sensation in the pelvis together with a feeling of lack of support and even notice a bulging of the vagina through the vulva. These disturbances are accepted as the consequences of vaginal distension brought about by the passage of such a disproportionate mass. It was natural, therefore, for the surgeon to assume that the vagina was overstretched and that the excision of a segment of the redundant tissue might alleviate her complaints.

As time passed on it was noticed that this procedure, while satisfactory in a moderate percentage of cases, failed to relieve other cases. Further search for a more efficient operative technic elicited the conclusion that the front and the back wall of the vagina and not the sides bulged through the entrance of the vagina in extensive relaxations. Some other structure, therefore, which lies in front and also behind the vagina must be damaged by the displacement required to permit the forceful passage of the child through the pelvis.

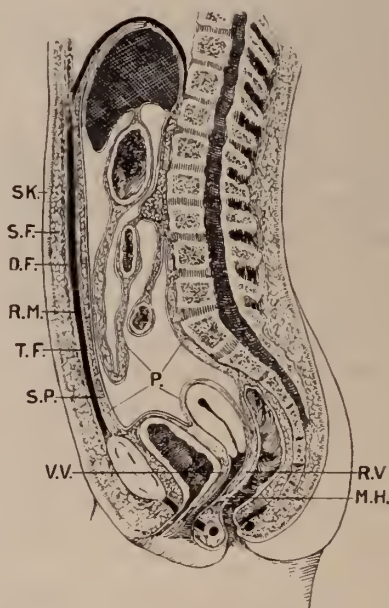


Fig. 1. A sagittal section of the abdomen and the pelvis showing that the various layers of the abdominal wall and the pelvic outlet are identical. The urethra, the vagina and the rectum separately perforate the various layers. The structures between the rectum and the vagina constitute the posterior perineal body while the structures between the vagina and the urethra constitute the anterior perineal body. The vagina, the uterus, the rectum and the bladder lie in a layer of tissue superficial to the peritoneum called the preperitoneal tissue. It is this structure, together with the blood vessels contained therein, which supports the pelvic organs and may be damaged as the head displaces the bladder to enter the true pelvis.

ANATOMICAL RELATIONS

Having noticed that the anterior wall of the undamaged vagina was flat and also that the trigone of the bladder, which lies in close relation to the anterior wall of the vagina, was likewise flattened, it was natural to investigate the structure lying between the vagina and the bladder which prevents a full bladder from effacing the vaginal lumen and likewise tends to



Fig. 2. A detailed description of the preperitoneal tissue enveloping the pelvic organs. The structure "B" has been called the pubo-cervical ligament; actually it represents a layer of preperitoneal tissue through which the inferior vesical vessels pass to supply the vaginal surface of the bladder.

keep the delivering child away from the anterior segment of the true pelvis. To do this, the abdomen was opened and the bladder was displaced from the posterior surface of the pubic bone until the urethra was exposed. This was cut across and the bladder was then carefully removed to expose the anterior surface of the vagina. In doing so, it was noted that the bladder and its lateral support could be diagrammatically represented by the fusion of two loops of intestine along their free border with the mesentery on each side extending to the lateral pelvic wall where it receives vascular branches from the hypogastric plexus. The bladder, itself, is enveloped by a layer of preperitoneal tissue, similar to the fibrous and fatty capsule of the kidney, and it is in this tissue that the blood vessels lie. The vessels

supplying the anterior and the abdominal surface of the bladder are tortuous and thereby permit urinary distension of the organ as high as the umbilicus, while the vessels supplying the vaginal surface of the bladder are straight and anastomose freely with those of the opposite side. This arrangement prevents posterior displacement of the full bladder; and consequently the lumen of the vagina and the rectum are not compressed even though the abdominal portion of the bladder may extend above the pubic bone.

During labor the child must pass through a bony pelvis which is barely large enough to permit its passage, even after the head has been compressed and distorted. Consequently the bladder, which normally occupies the fore-pelvis, must be displaced through a gradual process of traction and retraction until the base of the bladder and the structures attached thereto are stretched sufficiently to permit the child's head to fill the space normally occupied by the bladder. A rapid displacement due to a very short labor may result in lacerations,



Fig. 3. An antero-posterior view of the structure "B" in Fig. 2. The bladder has been removed from the anterior surface of the vagina after dividing the urethra.

1. Bisectioned urethra.
2. Levator muscle surrounding the urethra.
3. Bladder.
4. Cervix of the uterus.
5. Ureter.
6. Anterior vaginal wall and the mesovagina.
7. Mesovesica (Pubo-cervical ligament).
8. Inferior vesical artery.
9. Mesocervix.
10. Uterine artery.

while a prolonged labor, characterized by a very slow descent with little or no retraction of the head between the pains, shuts off the blood supply to the bladder; and the relative ischaemia resulting may cause permanent damage to the elasticity of the supporting structures and prevent proper involution following the delivery.



Fig. 4. An incision is made in the long axis of the vagina rather than after the inverted "T" technic. By putting traction on the Ellis clamps, the vaginal wall is drawn away from the bladder and lessens the chance of cutting into it.

PROPHYLACTIC TREATMENT

The progress of labor should be followed, and a second stage lasting more than two hours, with little or no descent of the head of the child, calls for assistance. A perineotomy frequently is all that is required. In hospitals a prophylactic low forcep delivery is recommended. The use of mid forceps, while apparently quite traumatic, is preferred to a prolonged arrest in the mid pelvis. Large doses of pituitrin and vigorous voluntary bearing down are not recommended, because of the tendency for lacerations during a quick delivery.

After the delivery of the child, at least 10-12 days of rest in bed are needed to permit proper involution of the distorted tissues. Getting out of bed too early, or straining, increases intra-abdominal pressure and prevents the efficient involution favored by resting. Any sub-involution remaining acts as a wedge for further distortion, through increased intraabdominal pressure, and favors the development of a cystocele.



Fig. 5. After the mucous membrane and the fibro-muscular coats of the vagina have been incised from the cervix to the anterior perineal body, clamps are placed on the edges of the vaginal flaps; and by blunt dissection the bladder is separated from each flap until a smooth, gray, glistening area is exposed lateral to the reddened bleeding midline area which represents the tear in the mesovesicae. Note that there is a cervico-urethral relaxation as well as a side-to-side redundancy.



Fig. 6. Mattress sutures, very superficially placed, begin in the region of the cervix of the uterus and reapproximate the torn or relaxed mesovesicae. This structure is intimately attached to the muscularis of the bladder. As the junction of the bladder with the urethra is reached, the involuntary muscle at the neck of the bladder is reapproximated and thereby improves the tone of the involuntary urethral sphincter. By continuing the mattress sutures the urethra is covered with its layer of preperitoneal tissue which ends as the levator and the deep transverse perineal muscles in the anterior perineal body are reached.

1. Reapproximated mesovesicae.
2. Levator fibers supplying the urethra.
3. Deep transverse perineal muscle.

SURGICAL TREATMENT

Most of the bulging of a cystocele is in the region of the cervix of the uterus, because this is the area which is displaced most as the head passes from the fully dilated cervix into the vagina. Should the passage be made suddenly, the rapid displacement may result in a tear which may extend in the mid line on the vaginal surface of the bladder to the urethra. A deep tear may divide the involuntary sphincter at the neck of the bladder; and if extended, may divide the levator and the deep transverse perineal muscles as they pass between the urethra and the vagina to act as voluntary sphincters of this duct. The damaged meso-vesica permits a herniation of the bladder which at first is supported by the anterior vaginal wall; but due to its function of receding before pressure the vagina relaxes and eventually becomes concave. With the menopause and the diminished venous engorgement resulting thereby, an additional supporting factor is removed and relief is sought.

To surgically expose the damaged meso-vesica an incision is made through the entire thickness of the anterior vaginal wall from the cervix of the uterus to the anterior perineal body, which is composed of levator muscle and deep transverse perineal muscle lying between the urethra and the vagina. The bladder is then mobilized from the anterior surface of the uterus and from each flap of vagina lateral to the mid-line incision.

A smooth, gray, glistening, fibrous tissue intimately attached to the bladder is exposed lateral to the roughened, bleeding area which represents the mid-line tear through which the bladder herniates. Interrupted mattress sutures placed superficially reattach the retracted meso-vesica and correct the side to side relaxation and close the hernial opening; while



Fig. 7. The redundant muscularis of the vagina need not be excised unless it is unduly scarred, because it will involute to a normal contour after the bulging cystocele has been corrected. A continuous suture is not recommended because of the tendency to shorten the anterior wall of the vagina. In the region of the cervix, the vagina is anchored near the level of the internal os to create the anterior vaginal fornix.

the cervico-pubic relaxation is corrected by re-attaching the meso-vesica a little higher than normal on the anterior surface of the uterus. Unless there is undue scarring of the anterior vaginal wall, it is unnecessary to excise the redundant tissue, for the involuntary muscle in the wall of the vagina will involute to normal after the pressure of the herniating bladder has been removed. It is this function which brings about the involution of the vagina after labor, or after several months of sexual abstinence.

To control oozing from the vascular meso-vesica and to support the repaired structure, the vaginal sutures should grasp sufficient tissue to take up the redundancy, and the vagina should be packed with a strip of gauze to offer additional support during the straining accompanying the recovery from an anaesthetic.

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DISCUSSION BY MEREDITH F. CAMPBELL, M.D., NEW YORK

It has been a great privilege to read Dr. Davies' excellent paper on cystocele. He has presented this subject from the standpoint of its obstetric etiology, which all will readily grant is the usual primary cause. Rather than discuss this subject by repetition of the material Dr. Davies has so splendidly given us, and the points he has made, I would like to direct your attention to another important etiologic

factor in cystocele, namely urethral obstruction and notably urethral stricture.

Urologists see a fairly large number of women with cystocele whose presenting symptoms are urinary frequency and dysuria. Careful examination of the urethra in the majority of these women reveals stricture, together with secondary urethrotrigonitis. Infection may or may not exist. These

strictures are more commonly situated in the middle or in the posterior third of the urethra; and while not of filiform calibre, they are often as tight as 10 or 12F. Moreover, there is often well-developed periurethritis with variably palpable periurethral infiltration. These lesions may be the late result of obstetric urethral trauma of ten to twenty years previous. Yet the fact that I have not infrequently encountered similar urethral obstructions in older female children with cystocele suggests the likelihood of congenital urethral stricture and consequent vesical urinary backpressure as an important etiologic factor in the production of some cases of cystocele.

An analogous bladder change occurs in males with prostatic obstruction. Moreover, we have ob-

served cystocele in virtuous elderly maiden ladies with tight urethral stricture which may be congenital, or inflammatory, or part of the picture of senile atrophic tissue changes.

Unfortunately most of these women with cystocele are informed by their surgeons that their bladder disturbances result from pressure of the uterus on the bladder. Yet uterine pressure in this instance is no more a factor than is rectal pressure. In short, if the surgeon will widely dilate the urethra (to 34 or 36F), the urinary symptoms will be relieved wholly or in gratifying measure. Unless he dilates the urethra widely following the cystocele operation and eradicates all urethral obstruction, the success of his ever-so-well executed operation is seriously endangered by the unrecognized urinary backpressure within the bladder.

CHRONIC PARANASAL SINUSITIS,—A MEDICAL PROBLEM*

By GEORGE H. LATHROPE, M.D., F.A.C.P., Newark, N. J.

Read before the Section in Medicine of the Annual Meeting of The Medical Society of New Jersey, June 7, 1939.

In the search for foci of infection as a cause for various types of chronic invalidism, stress is frequently laid on teeth and tonsils, with too little regard to the presence and importance of chronic sinus disease. It is a commonly admitted fact that infection in *latent form* of the mucous membrane of the nose and its accessory sinuses is well-nigh universal in adults living in this climate. The question therefore centers not so much on determining whether infection is present, as on the determination, first, of how much, *if any*, trouble it may be causing; second, in just which sinus or sinuses the focus may exist; and third, what to do to be rid of, or ameliorate it.

POSTERIOR SINUS DISEASE

Disease in the frontal and maxillary sinuses or anterior group is readily recognized by transillumination and roentgenogram, as well as by more or less definitely localizing symptoms. These patients in fairly large proportion seek the specialist early, with or without the intervention of the practitioner. On the

other hand, the ethmoid-sphenoid or posterior group, when diseased, evoke more veiled local manifestations, cannot be recognized by transillumination, and do not lend themselves readily to roentgenographic diagnosis. As a result, it is some time before infection in this area is suspected, and the patient has usually been in the hands of the medical man for varying lengths of time before being referred to the rhinologist. Therefore, posterior sinus disease is, in its early stages at any rate, essentially a medical problem.

Infections of the posterior sinuses (ethmoids and sphenoids), without demonstrable involvement of either frontals or antra, comprised well over half of 104 consecutive cases of sinusitis studied for this presentation; and in the remainder, the posterior groups were involved along with one or the other of the anterior sinuses in all but ten. That is, ninety-four, out of 104, showed infection in this posterior area.

Table one represents the incidence graphically and constitutes ample evidence of the great importance of recognizing infection in the ethmoid-sphenoid area.

* I am indebted to my colleague, Dr. L. A. Peer, for access to his records, which have furnished much of the data employed in this study.

TABLE I.

LOCATION OF THE INFECTION IN 104 CONSECUTIVE
CASES OF CHRONIC SINUSITIS

Posterior group alone	60, or 58%
Anterior group alone	10, or 10%
Mixed group anterior and posterior....	34, or 32%
Posterior group to anterior group as...	6 to 1
Mixed group number about one-third of the total.	

PATHOLOGY OF THE POSTERIOR GROUP

A study of this posterior group becomes then a matter of paramount importance; but before going further, in order to appreciate differences in type of treatment and in the time element involved, something must be said as to pathology. In general, two types of chronic inflammation of the accessory nasal sinuses are encountered, (a) the suppurative, and (b) the hyperplastic. In 100 consecutive cases of antrum infection there was an almost equal incidence of the two types.¹ It is highly probable that a similar proportion exists in the posterior sinus infections; but the difference in accessibility and satisfactory roentgenographic study makes this fact less readily demonstrable with the posterior than with the anterior group. At present the similarity between the two may reasonably be assumed without actual proof of the fact.

The microscopic appearances which afford differentiation between the two may be briefly described. In the suppurative form of sinusitis, the mucous membrane is somewhat thickened. The mucosa is eroded and covered with exudate, and its ciliated epithelium is evident here and there. In the submucosa there is oedema and infiltration with leucocytes, and the glandular elements are present.

In the hyperplastic form there is relatively more thickening of the mucous membrane, and this may be considerable. The epithelium is degenerated and flattened; the cilia are lost; the submucosa is infiltrated with round cells; and the glands are much reduced in number. There is little or no surface erosion, and relatively little exudate.

In both types, but particularly in the hyperplastic, bacteria may be demonstrated deep in the submucosa by stained sections; or may be obtained in pure culture after operative re-

moval of the mucous lining of one of the sinuses by carefully sterilizing the outside of the tissue, grinding it up, and spreading it on suitable culture media. (Watson-Williams,² R. A. Cooke.³)

The two types, of course, merge in some cases; and whether the suppurative form is an early stage of the hyperplastic, or vice versa, has not been proven. Both are probably different phases of the same fundamental process. The distinction is, however, of clinical interest, because, as will be shown later, a considerable number of the hyperplastic group present no local subjective symptoms, and, giving rise to a minimum of discharge, are rarely recognized in an early stage. Distinction between the two groups is of importance also in treatment and prognosis, as will be shown later.

A comparison of tables two, three and four will serve to give an idea of the general similarity in subjective symptomatology of the various groups.

TABLE II.

SUBJECTIVE SYMPTOMS IN 100 CONSECUTIVE CASES
OF ANTRUM DISEASE

<i>General</i>	<i>Local</i>
Lassitude	Discharge
Repeated colds	Head pains
Rheumatic pains ...	Obstruction
Cough	Sore throat
Gastro-intestinal ...	No local subjective
Asthma	symptoms
	(11 hyperplastic
	5 suppurative)

TABLE III.

SUBJECTIVE SYMPTOMS IN 60 CONSECUTIVE CASES OF
POSTERIOR SINUSITIS

<i>General</i>	<i>Local</i>
Lassitude	Discharge
Repeated colds	Head pains
Rheumatic pains ...	Obstruction
Cough	Sore throat
Gastro-intestinal ...	No local subjective
Loss of weight	symptoms
Asthma	
Visual defects	
Dizziness	

TABLE IV.

SUBJECTIVE SYMPTOMS IN 34 CONSECUTIVE CASES OF
MIXED (ANTERIOR AND POSTERIOR) SINUSITIS

<i>General</i>		<i>Local</i>	
Lassitude	23	Discharge	16
Repeated colds	11	Head pain	13
Rheumatic pain	15	Obstruction	3
Cough	9	Sore throat	1
Gastro-intestinal	1	No local subjective	
Loss of weight	2	symptoms	10
Asthma	4		
Visual defect	0		
Dizziness	4		

Without going into any detailed study of the various complaints made by these sinus patients, one is struck by the uniform predominance in all these groups of lassitude, frequent colds, and so-called rheumatic aches and pains.

Of the five cases of eye complications noted in table three all were serious—iritis, choroiditis, optic neuritis, and one had a multiple sclerosis. The large proportion of antral infections associated with asthma is interesting, as well as the greater tendency for the antrum cases to complain of gastro-intestinal symptoms, loss of weight and cough.

The striking thing on these tables, however, is the comparatively large number of patients who had no subjective symptoms whatever that had led them to think of their nasal sinuses as being even remotely concerned in their disability. This fact is summarized in table five.

TABLE V.

The absence of local subjective symptoms was noted in 35 out of 194 consecutive cases of chronic sinusitis as follows:

In 100 cases of antrum disease	16
In 60 cases of posterior sinus disease ..	9
In 34 cases of mixed anterior and posterior	10
—	—
194—Total all types	35, or 18%

In table two, among the sixteen cases which had no local subjective symptoms, eleven were definitely of the hyperplastic type, and only five were suppurative.¹ That the same proportion obtains in the cases with posterior sinus involvement seems probable; but we have been unable to prove it satisfactorily because they cannot be studied roentgenographically as readily as the antral infections.

The fact remains that 18 per cent of the total of 194 cases of all types were not aware that their nasal sinuses were involved in their disability; and they had to be persuaded, often much against their will, to have an examination by the specialist. Furthermore it was not uncommon that, when they reached the rhinologist, he was not impressed with the presence of nasal pathology because of the absence of frank discharge; and he, in turn, had to be persuaded that there was something for him to do.

The following case reports are illustrative.

CASE 1

Mr. M. R. C., a businessman of forty, married, reported for examination November 2, 1937. He complained of feelings of profound lassitude lasting for two to four days, and recurring every two or three weeks. Three months ago pain in left shoulder and arm, which improved after an abscessed tooth was extracted. Few colds, no sore throat, in fact no other complaints.

Examination showed an apparently healthy man of standard weight; pulse rate 76; blood pressure 115 systolic, and 80 diastolic. There was a laparotomy scar right lower quadrant.

The mucous membranes of nose and throat were congested, inferior turbinates enlarged, septum crooked, but with little interference with breathing.

Blood count—Red blood cells 4,800,000; hemoglobin 94 per cent; white blood cells 11,000, polynuclears 63 per cent, over two-thirds of which were immature.

Diagnosis of a probable posterior sinusitis was made, and he was referred to a rhinologist near his home where it would be convenient for him to go for treatment. He returned in a week reporting that the rhinologist had told him there was nothing the matter with his sinuses.

Patient and rhinologist were both persuaded to attempt a trial period of treatment.

He reported next on June 30th, 1938, stating that he had had several series of treatments and felt much better.

March 3, 1939, reports that for eight months he has been free from his attacks of lassitude, and the only treatment in that time was recently when his sinuses had flared up and he had gone to the rhinologist for the first time in that period. A letter from the rhinologist at that time confirmed this and stated his conviction that posterior sinus disease had been the cause of his original symptoms of lassitude.

The patient was last seen May 11, 1939, and was still entirely free of his former unpleasant fatigability.

Case one had no treatment of any kind during the period reported, except the local treat-

ment of the rhinologist. He was too busy to take any vacation or to shorten his hours of work; and pending the result of trial treatment he was allowed to continue his regular routine without modification. He had no localizing symptoms which had led him to be suspicious of his nasal area, and both he and the rhinologist had to be persuaded to a trial of what treatment would accomplish.

CASE 2

Mr. S. A. J. was a very hard-working lawyer who had taken little or no holiday for several years, and had worked long hours daily. He is married, and fifty-eight years of age. He was referred by his physician February 14th, 1939. He complained of weakness and indigestion. He had been able to work only part time through the previous Autumn because of the profound exhaustion which would come on about midday. In the middle of December he developed a cold from which he recovered in due course, but has been in bed ever since because he has been so exhausted that he cannot be up for any length of time. For the past month he has had considerable bad-tasting discharge back of nose and throat. He has had indigestion of the flatulent type with dull pains in the epigastrium. Tonsillectomy in 1930 because of colds, which have not been so frequent since.

Examination: Weight was 33 lbs. below standard; there was slight pallor and some fine tremor of the fingers; temperature 98.6 by mouth, pulse 92, and blood pressure 140 systolic and 90 diastolic. The mucous membrane of the nose was pale and oedematous; the turbinates were enlarged; the septum was deflected to the left, and he had very poor breathing on that side. The pharynx was rather intensely congested. His blood count: Red blood cells 4,300,000, hemoglobin 84 per cent, white blood cells 10,300, polynuclears 70 per cent, two-thirds immature; urine essentially negative.

Diagnosis: Chronic posterior sinusitis.

He was referred to Dr. L. A. Peer, whose examination resulted in a diagnosis of left maxillary and posterior sinusitis. Surface cultures gave a hemolytic staphylococcus aureus from both sides.

A few pack treatments were given which gave a feeling of relief for a few hours, but resulted in nothing lasting; and owing to the serious obstruction both to breathing and to drainage on the left side by the deflected septum, operation was advised.

March 7th the septum was straightened under local anaesthesia, and an opening made into the left antrum.

Under the administration of dilute hydrochloric acid the indigestion had already begun to disappear.

Since then he has made steady improvement. He was last seen on May 22nd, eleven weeks post-operative. He tires only if he does too much, but no longer has the feeling of profound exhaustion experienced all through the Autumn and particularly after the cold in December. A blood count on

April 4th, 1939, showed: Red blood cells 4,200,000, hemoglobin 81 per cent, white blood cells 9,000, polynuclears 58 per cent, only one-third of which are immature. Urine negative.

Treatment has been by argyrol or coryfin packs, a few displacements, and three or four antrum irrigations, but none for six weeks.

This is a case of a mixed anterior and posterior sinus involvement, and illustrates the importance of establishing drainage and proper breathing space. It is notable too that the patient had no idea he was not breathing properly till it was demonstrated to him by closing his right nostril. He also had nothing that he thought referable to his nose till the development of considerable postnasal drip about four weeks prior to coming for examination. He has still considerable distance to go before he will feel his normal self, but the marked improvement that has followed the attack on his sinus infection appears to justify fully the idea that infection was a major cause of his complaints.

CASE 3

Mr. S. H. was a retired lawyer, unmarried, and sixty-seven years of age on January 25, 1932, when he reported complaining of a backache and lassitude which followed a cold contracted seven weeks previously. He had always regarded himself as "gouty", and had had various aches and pains chiefly in the lumbar regions; but he had had nothing till this last cold, which he referred to the nasal area. Since that cold there had been an annoying postnasal discharge, as well as a more annoying aching and stiffness of his lumbar muscles, pain in the right wrist, and a marked fatigue in midafternoon.

Examination: Mucous membrane of the nose swollen and congested, but no discharge seen. Pharynx congested; his blood pressure was 135 systolic, 85 diastolic; pulse 76; heart questionably enlarged, rhythm regular and no murmurs; there was no oedema. Red blood cells 4,300,000, hemoglobin 87 per cent, white blood cells 7,800, polynuclears 71 per cent, about three-fourths of them immature.

He was referred to Dr. L. A. Peer, who found a left antrum cloudy on transillumination. The antrum was washed and the return was clear. Culture failed to give any growth. Lipiodal was injected, and roentgenogram showed very incomplete filling due to a much-thickened mucous membrane. A second washing returned clear, and culture produced two colonies of staphylococcus (thought to be contamination).

A third antrum wash brought some discharge, and washings were repeated bi-weekly till March 9th (i.e., over a period of six weeks). Roentgeno-

gram with lipiodal, in the left antrum on this date revealed that antrum completely filled—i. e., there was now no thickening of the mucous membrane. The patient had improved steadily from the time of the first antrum washing, and had had no other treatment. His symptoms had entirely disappeared. He was given no further treatment, but was examined semi-annually, and had no recurrence of either rheumatic pain or of local nasal symptoms up to the time of his death, from coronary thrombosis in August, 1937, at the age of seventy-two.

This is the hyperplastic type of antral disease. Washings were clear and sterile at the first examination by the rhinologist. The backache and pain in the wrist disappeared after a few treatments. The congested appearance of nasal mucosa and pharynx, together with the large number of immature polynuclears in the blood count, furnished the clue which led the internist to refer the patient to the specialist. His chief interest lies in the fact that it was not till the third and subsequent antrum washings that any discharge was obtained, and then but little.

DIAGNOSIS

The early recognition of sinus disease by the general practitioner is a matter, first and foremost, of proper evaluation of the patient's history. A comparison of tables two, three, and four will make clear the uniformity of generalized symptoms as presented by both anterior and posterior sinus infections. By far the most prominent of these is *lassitude*, which is not only a common complaint, but is sometimes very strikingly the *sole* complaint, and the one which leads the patient to seek advice. Various muscle or joint pains and frequent colds appear with considerable regularity.

It may be stated here that the presence of any bronchial infection—bronchitis, bronchiectasis, emphysema, infective bronchial asthma, etc.—is almost diagnostic of an upper respiratory tract infection; for they are virtually always secondary to such infection, and practically never primary (Cooke³). These or other of the less common symptoms listed, singly or in combination, if not definitely explained on some other basis, should lead to a consideration of focal infection as the source of disorder.

Pain somewhere in the head is a complaint of many sinus victims, and in the antral and frontal cases may be referred fairly directly to the sinus involved. It is not so distinctive with the posterior sinuses, but may nevertheless afford a definite clue. In its most characteristic form in ethmoid-sphenoid infection it is located behind one or both eyes, and pressure on the eyeball may accentuate it by relieving and then making tension on the optic nerve, already made sensitive by its proximity to a diseased sphenoid cell.

Pain in the back of the head and neck should arouse suspicion. This is probably due to secondary or referred irritation of the branches of the cervical plexus, which if severe, may involve the upper brachial plexus nerves and be referred to the shoulders and down the arms, simulating at times the pain of angina pectoris.

The appearance of the pharynx is more or less characteristic. There may be a smooth, intense congestion, and muco-pus may be seen draining from high in the naso-pharynx and streaking, or even completely coating, the posterior pharyngeal wall. In cases in an early stage, or with less congestion, there are often seen reddish streaks running down the posterior wall, revealing the course of the lymphangitis set up by the posterior sinus infection. As stated above, the only tools required are a light, a nasal speculum, and a tongue depressor. Time needed, about three minutes.

Nothing has been said about roentgen diagnosis in these conditions. It is of course very useful in the case of antral and frontal involvement; but under present conditions of technic and interpretation it is almost useless in posterior sinus disease, except in the case with marked pathology. The practitioner must be able to make up his mind on the basis of a careful history, supplemented by his examination. He may leave, if he wishes, the question of x-ray to the specialist. However, if the latter reports that x-ray does not reveal any trouble with the sinuses, the internist must not accept that statement for the ethmoid-sphenoid group against his own clinical judgment. He

should insist on a series of treatments being carried out as a therapeutic-diagnostic test.

Shambaugh⁴ states in a recent article:

"Diagnosis * * * is particularly difficult in those low-grade, chronic infections of the ethmoid sinuses in which the nasal passages appear normal on one or more examinations, and in which any symptoms pointing directly to the sinuses are so slight as to be almost nonexistent, and yet in which there is sufficient systemic absorption from the ethmoid infection to cause very definite systemic symptoms."

It must be noted especially that 18 per cent of the 194 cases of infection of the various sinuses (table five) had *no* local subjective symptoms. In *all* of these cases treatment had to be instituted on the therapeutic-diagnostic basis. Both rhinologist and patient had to be convinced of the desirability of a series of five or six treatments to determine the correctness of the internist's diagnosis. What happens in antrum cases of this type is shown by the reported case—(vid. sup. case three). The first, and perhaps second, antrum washing may be clear; not only clear, but sterile. Then comes a thick mucoid discharge with the second or third washing, and the patient is very likely to report at the next visit that there was a definite improvement in his feelings for twenty-four to seventy-two hours after that treatment. Persistence in treatment thereafter confirms the diagnosis and relieves the patient.

TREATMENT

The practitioner or internist must have definite ideas about the general principles of treatment, although he need not concern himself with details which can safely be left to the specialist. He cannot shirk this responsibility, for after all, the essential condition is focal infection which is his province; and the rhinologist, with all due respect to his ability and acquirements, is merely a therapeutic agent.⁵ The situation demands an *entente*, or the establishment of team work, between the practitioner and specialist if the best results are to be obtained.

The first consideration is to obtain *drainage* of the affected sinus, with or without such topical applications as the rhinological fashion of the time may demand for purposes of reduc-

ing inflammation. Drainage may be gained by shrinkage or displacement treatment, and topical applications alone, carried on for a sufficient length of time and repeated in courses of several treatments two or more times a year.

With the posterior sinus infection especially it must be remembered that great patience and persistence are essential, based on the effect observed on the generalized or focal infective conditions of the patient, not on the presence or cessation of discharge.

Next, if proper drainage of the affected area cannot be maintained in this way, it may be necessary to remove portions of obstructing turbinates or to correct a deflected septum.

Proper aeration is the next essential, for insufficient breathing space may induce symptoms of fatigue through inadequate oxygenation, and is of great importance to a normal physiological balance entirely apart from considerations of absorption of infective toxins. Polyps should always be removed.

In intractable cases, where the ordinary or simple operative measures fail, it may be necessary to resort to radical measures. This means the complete exenteration of the mucous membrane of the involved sinus. In cases of choroiditis and other serious visual disturbances, and some of the infective asthmas, it may prove necessary to be rid at once of all infective areas, and this can be accomplished by radical means alone.

It is evident, in the case of suppurative sinusitis, why drainage and topical applications are beneficial. In the hyperplastic cases, with little or no discharge, it is probable that improvement results from counter-irritation. After a few treatments these patients begin to have a discharge and then to feel better; and in the antrum infections x-ray with lipiodal injection shows a marked shrinkage in the thickness of the mucous membranes as in the case cited above.

It has been mentioned that difference in the underlying pathology involves difference in prognosis and treatment. This is largely in the time element. In general, the mucous membrane of the suppurative case is not so thickened, the inflammatory reaction is nearer the

surface, and it yields more readily to establishment of drainage, and to the direct contact of cleansing and stimulating applications. The hyperplastic case has a much-thickened membrane, with bacteria lying deep in the tissue, and often needs considerable counter-irritation before discharge becomes established and the healing process sets in. This is essentially the type that requires persistent treatment. After the first prolonged course of local applications, with removal of obstructing polyps, turbinates, or septum, and when the general symptoms of lassitude and rheumatic manifestations have subsided, it is a good plan to stop all treatment (except a spray which the patient can use at home) for a period of one or two months; and then give another series of six or more treatments, repeating this at intervals of three or four months for the next year. In some cases symptoms either local or general will have recurred in these intervals, and the patient must be instructed to come at once if he notices anything wrong,—and not to await the expiration of the vacation period. But he must be impressed that to get good results he must return for follow-up observation and some treatment even though no symptoms develop. With intelligent patients this is not difficult once they understand their problem, and once they have experienced the relief that can be obtained.

CONCLUSION

In the series of sinus infections here presented there was a very appreciable number which had no localized subjective symptoms,—35, or 18 per cent, of 194 consecutive cases of chronic sinus disease. In a good many of the remainder who had more or less symptoms which they referred to their respiratory tract, there was often difficulty in persuading the patient (and sometimes the rhinologist) that this was the cause of the generalized symptoms.

It becomes essential then that the medical man, to whom many, if not most, of these cases appeal, must be able to make a diagnosis, not alone of focal infection, but also of the area or focus from which the symptoms arise.⁵

He must draw his conclusions from an intelligent history, and from his examination of nose and throat. If he cannot convince the specialist otherwise, he must ask for a trial of a short series of either pack or displacement treatments, to observe whether drainage is improved and whether the patient obtains any relief.

Schambaugh⁴ has stated very flatly that the Proetz displacement is the best method of diagnosing ethmoid infection. This is in line with our own experience.

The diagnosis established, persistence and patience are needed. Drainage is all-important, and if not obtained by conservative measures, should be sought through such operative procedure as the removal of polyps, turbinectomy, or straightening of a deflected septum.

Where vision is seriously impaired or threatened, and in intractable cases of infective asthma, exenteration of the mucous membrane of one or more sinuses may be necessary.

SUMMARY

The following propositions have been put forward:

1. That chronic paranasal sinusitis is a common focus for engendering generalized symptoms; and because of its tendency to be latent or slight in its local manifestations, it often remains for a long time unrecognized.

2. That therefore it is a condition which lies in the province of the general practitioner or internist, who must learn to recognize it early.

3. That, once diagnosed, persistence and patience in treatment are essential.

4. That, in general, conservative measures, if carried out long enough, are satisfactory in their results; but the radical means must be employed at times for securing better drainage and relief of obstruction to breathing.

5. That in occasional cases of intractable infective asthma, or in serious damage to the structure of the eye, exenteration of the mucus membrane of the involved sinus is indicated.

6. That, finally, the whole problem belongs essentially to the practitioner or internist, who must not only diagnose the condition, but must be prepared to direct the treatment.

DISCUSSION

DR. NORMAN W. BURRITT, SUMMIT, N. J.

As to what constitutes the treatment of these conditions vary all the way from radical surgery, to conservative packings with anything from an innocuous oil to a most irritating chemical antiseptic. The discussion continues to go on in the Academy of Laryngology and Otolaryngology, as to what is the thing to do. So far as the rhinologist is concerned, he hasn't made up his mind what to do.

They are exceedingly difficult cases to take care of, so far as I personally am concerned.

I see no reason at all for considering the gravity of an investigation of the posterior sinuses too great for diagnosis purposes. I think that delay, particularly in the presence of severe symptoms such as the partial or total loss of vision of an eye, or the long-continued involvement of joints from an infection, should warrant our doing something real to determine whether or not there is infection in the sinuses.

In regard to that I call to mind one case that Dr. Lathrope saw that I had also seen and I had opened up one sphenoid space of this patient and I found infection there. The patient was so much better that I took it for granted that that was all there was there. Dr. Lathrope insisted there was infection in the sinus spaces somewhere. An attempt was made to instill lipiodol into the patient's sphenoid on the opposite side from the one that was opened, and the patient had a very severe reaction, and it was an exceedingly painful procedure; and four days later, with much less pain and discomfort to the patient, we opened up the right ethmoid-sphenoid space and found what Dr. Lathrope said was there, which I had not recognized at the time.

I think the internist, with his careful study of the general conditions and the local signs, can very frequently point the rhinologist's finger to the spot with more accuracy than we ourselves can see it.

DR. WILLIAM G. BERNARD, MURRAY HILL, N. J.

I think Dr. Lathrope deserves a great deal of credit and is very brave in bringing this interesting subject to our attention.

One of the most impressive findings was the fact that in thirty-five out of 194 cases there was sinus disease, and with no subjective symptoms.

Another interesting phase is the relation between sinus, posterior sinus disease, and certain conditions of the lungs. I believe Dr. Lathrope will recall a case of a nurse who on physical examination showed

definite findings in the left apex. He saw this case in consultation. An x-ray diagnosis was made, and the diagnosis was tuberculosis.

Dr. Lathrope saw the case and suggested a period of sinus treatments, posterior, at weekly intervals, and, after a reasonable period of time this patient shows that the lung condition has cleared up—and it has been possibly five years now, and the patient is going back to her occupation.

I think this is very interesting and has given us a lot of food for thought.

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THE MEDICAL APPROACH TO THE GALL-BLADDER PROBLEM

By S. BERNARD KAPLAN, M.D., Newark, N. J.

Read before the Annual Meeting of The Medical Society of New Jersey, June 6, 1939.

A critical analysis of experience and a survey of the medical and surgical management of gall-bladder disease leads to the inevitable conclusion that present-day therapy is inadequate. From the internist's and gastroenterologist's point of view the use of low fat, low cholesterol diet, in conjunction with chologogues and biliary salts, with occasional non-surgical biliary drainage, comprise the average conception of the medical management of gall-bladder disease; and this has remained unchanged for these many years. From the surgeon's point of view, the consensus is that, if there is any evidence of any pathological changes in the gall-bladder, the structure should be removed.

I feel that I cannot concur with either of these generally accepted ideas of gall-bladder management. A great majority of patients with low-grade right upper quadrant symptoms can be as completely, or more completely, relieved by proper medical management than by surgery. Yet the inadequacy of the present proper medical management of gall-bladder disease accounts for the intrusion and dominance of surgical treatment. We still feel that medical management based upon the physiological principles of the biliary tract will relieve symptoms, and can restore to normal those roentgenological functioning gall-bladders which gave pathological findings on previous examination. Therefore, as one of the chief factors concerned in the production of upper abdominal distress, the bladder has become of great significance to the gastroenterologist.

In a review of admissions to the gastrointestinal departments of two of the largest clinics in the City of Newark, gall-bladder disease was found to be the causative agent in over 48 per cent of all organic cases admitted. The apparent futility in the control of these cases, both medically and surgically, has led us to establish a method of assimilating all current literature and all experimental data in relation to a new approach to this most important con-

dition. Of this I will have more to say later in this paper.

In a review of the many medical treatments offered to the physician the principles have been based upon several fundamental conditions of the diseased gall-bladder. These are:

1. Stasis in the biliary tract.
2. Infection of the gall-bladder.
3. The varying degrees of hepatitis and liver damage accompanying the changes in the gall-bladder.
4. Pericholecystitis with adhesions to the adjacent viscera as in ulcers of the duodenum.
5. Accompanying pancreatitis, the result of stasis or blocking of the sphincter of oddi.

The exact rôle of each factor in the production of the characteristic syndrome of gall-bladder disease is not definite and varies in each individual patient.

The *stasis* in infection of the gall-bladder was postulated as far back as 1892, by Naunyn, and since that time many observers have been convinced of this theory. Experimental evidences submitted by Aronsohn and Andrews in 1938 have confirmed it; and in our laboratory in the past year we have likewise concluded that gall-bladder treatment will eventually be entirely based on it. Elimination of bile stasis, or relief thereof, was the basis of Lyon's non-surgical drainage.

In the factors of primary infection and re-infection in producing of diseased gall-bladders, advocates have also advanced many treatments; and still more observers, especially recent observers as Aronsohn and Andrews as late as 1938, have been unable to substantiate any reason for this theory. My associates and myself have likewise cultured bile from many diseased gall-bladders at operation, and only once have been able to grow pathogenic organisms. Numerous others report having obtained only sterile cultures from human gall-bladders that were diseased.

The third problem in which the medical treatment must cope is the liver damage asso-

ciated with pathological changes in the gall-bladder. Flint in 1930 reported a series of cases in which gross and microscopic studies from biopsy specimens removed at operation demonstrated hepatitis associated with cholecystitis in the majority of cases. Previously levulose tolerance tests agreed with the microscopic findings of liver damage. We have seen that certain gall-bladder cases present symptoms far more referable to a diseased liver and biliary tract than to the gall-bladder alone. The question of surgical or medical treatment here is a debatable one, as we will see in due course of time.

The theory which we feel may eventually be conclusively proven and which is uppermost in the minds of most gastroenterologists, and which we are desperately trying to prove in our present research, concerns the qualitative differences in the bile salts and bile acids secreted by the liver.

Experiments indicate a far higher degree of toxicity for some of the unconjugated bile acids. The present limitation of bile salts chemistry makes it impossible to recognize even large amounts of such materials in the quantity of bile recoverable from a gall-bladder. We hope in the near future such progress will be forthcoming. This theory mitigates against that of bacterial infection, and this fits in well with facts for chemical, and against bacterial, theories. The frequent afebrile cases and failure to grow organisms in many cases are all consonant with such a chemical mechanism. Aronsohn and Andrews have shown that the low values from bile acids found in most cases of acute gall-bladders is explained on the assumption that the original high concentration causes an edema which permits the rapid leaking out of the contents by osmosis. This was proven in experiments in the staining of the local peritoneum. A quantitative study of the toxic effect of bile salts was made by replacing gall-bladder bile, in the dog and rabbit, by bile concentrated previous to injection. Bile concentrated to one-half its volume proved to have a marked effect on the gall-bladder wall. The shortest time in which this reaction was caused in the dog was three

minutes, and it greatly resembled the human cholecystitis.

I personally have the feeling that the majority of our pathological gall-bladders today can be retraced to a fault in the manner of living of the human race. Our method of living, our premasticated foods, undigested diets and nervous tension all contribute to a delay in gall-bladder emptying, with a resultant stasis.

Mock, Brown, and Mockalt, of Chicago, reported medical management of gall-bladder disease on 120 patients, and concluded that patients can definitely be managed on medical treatment so as to become symptom free, and roentgenologically show a normal emptying gall-bladder.

The choice of medical treatment I believe which will respond physiologically are: 1, the gall-bladder dyskinesias; 2, chronic cholecystitis, where no calculi are present; and 3, chronic cholecystitis with large, soft calculi, limited in number, and where no calculi or colicky attacks are evident. All this is with the proviso that, if the response to a reasonable trial is not effective, surgery must be resorted to.

The gall-bladder dyskinesias will respond very readily to a form of symptomatic treatment relative to colon spasm. Irritable colons are predominantly the cause of this type of gall-bladder, due to approximation of the transverse and ascending colons. A mere bland diet, antispasmodics and sedatives, will result in complete alleviation of all symptoms both subjectively and objectively.

In the many treatments of gall-bladder disease advocated, results are still unsatisfactory. A great many chologogic preparations are being used to stimulate bile flow. Magnesium sulphate has been used for many years because of its relaxing effect on the sphincter of Oddi. But this is usually combined with a low fat, low cholesterol diet, and the inconsistency is readily conceivable. Magnesium sulphate achieves a direct antagonistic action to that of the decreased fats, as low fats places the gall-bladder at rest, while fat in the duodenum causes an emptying of the gall-bladder. Ivy has persistently shown that fats such as cream and butter or olive oil are more effec-

tive than magnesium sulphate. Since even most patients are chronically constipated, continuous use of magnesium sulphate will generally result in the development of a highly irritable bowel with reflex pylorospasm, and this may result in the production of a gall-bladder dyskinesia.

Limitation of foods high in cholesterol has proven very inconsistent by such well-known researchers as Andrews, Whitaker, and Collins. Andrews in over 200 cases with gall-stones made studies of the blood levels of cholesterol, and found no correlation,—that is, increasing cholesterol in diet does not increase cholesterol in the bile. We have noted a cholesterol rise only in those patients with obstructive jaundice, where there is primary changes in the liver.

Primary infections have formed a basis of treatment over a long period of time by the use of such drugs as salicylates, hexamines, etc. This form of treatment has been of no avail, and results in causing an irritation of the stomach mucous membrane. Rehfuess and Nelson in experiments on infection as a cause have come to the same conclusions.

Stasis is of the greatest practical importance in the development of cholecystic disease and its complications, because it not only influences the chemical and metabolic functions, but by disturbing the secretory and motor functions, it contributes markedly to the awakening of a latent, inactive infection to an active process in one of the most vital systems of the body. Stasis, partial or temporary, caused by inhibition of the normal flow of bile, may be produced by, 1, marked changes in the bile, such as thickening; or 2, by partial occlusion of the common duct by a small stone or plug of mucus by a change in the normal mechanism by which the gall-bladder is evacuated, namely simultaneous contraction of the gall-bladder and relaxation of the sphincter of Oddi (so-called spastic biliary dyssnergia). Best and Hicken have clinically demonstrated roentgenologically and clinically a condition of colicky pains, and demonstrable spasm of the sphincter of Oddi, and with failure of evacuation of the contents of the common duct. Partial or complete relief of symptoms, pain and colic

with demonstrated evacuation of the common duct, was obtained in most cases by the use of medical and non-surgical drainage measures. This demonstration provides us with a rational basis for the prevention and treatment of biliary stasis, and this is the rational approach to the medical treatment of gall-bladder disease.

With biliary stasis as the accepted theory of cholecystitis, treatment should be directed toward this dysfunction. We have instituted two separate methods of treatments in our clinics today in an effort to correlate a rational means of improving these patients. Patients are relegated as, 1, those of the extremely fat type; and 2, those of normal weight.

1. The very obese individual who is burdened with fat we are reluctant to add more weight, and have therefore resolved the treatment along old lines. Bile salts in the form of oleic acid or cholegogues, were prescribed, along with a minimum fat and carbohydrate diet. This treatment has been more successful in the chronic cholecystic type who show no demonstrable stones or calculi. Digestive symptoms, constipation, and pain were strikingly removed. Although treatment is here prolonged, where no great improvement was noted, non-surgical drainage was instituted at frequent intervals, and additional improvement was obtained.

2. In the case of patient of normal or average weight, the treatment advocated was that of keto-cholanic acids, and a diet of increased fat and carbohydrates. The keto-cholanic acid used was that of Searle & Co., which is a mixture of acids containing oxidation products of all natural bile acids found in human bile in normal proportions. Administration was in three and three-quarter grain tablets, giving one tablet, three times daily, after meals. Along with this, antispasmodics and sedatives were given. The most consistent subjective improvement was found to parallel the objective improvement as shown by x-ray. The improvement may be due to increased activity of the gall-bladder, or of the gall-bladder wall, or to improved mechanical flow resulting from increased amount of bile from the liver. I should further state that care should be observed in leaving out those cases with calculi. Certainly

keto-cholanic acids should not be used in these cases.

Although we are heartily in accord with the efficacy of medical management based upon sound medical judgment, we do not wish to be misconstrued in minimizing the place of surgical treatment.

In the first place, the clinician attempting medical management must know that procrastination in the face of well-defined surgical indications is hazardous.

We hold the opinion that the management of gall-bladder disease can never be designated either as solely surgical, or as entirely medical. The medical management has its failures; so, too, does surgery find itself lacking. A study of statistics concerning the surgical treatment suggests that surgery alone has proved inadequate in a considerable portion of the cases. The point we wish to emphasize is that there should be a definite revision of ideas as to just what constitutes adequate medical management, and what are surgical indications.

We have formulated the opinion that the following cases should be referred to the surgeon for operation:

1. Chronic cholecystitis: Those patients who do not respond to a reasonable trial period of medical therapy (and not after too great delay), and chronic cases in which non-surgical drainage has been given and microscopic bile from the gall-bladder shows evidence of calcium bilirubinate crystals.

2. Calculous gall-bladder where demonstrable stones are shown on x-ray examination.

3. Obstructive jaundice due to a common duct stone, stricture of the common duct, or to extrabiliary tract inflammation with compression of the duct as by tumor. These patients should be operated preferably when the jaundice subsides or lessens, although occasionally operation is indicated to save the patient's life,—empyema of gall-bladder where the patient is having chills and fever and steadily growing worse.

5. Obstructed cystic duct with dilated gall-bladder, where the gall-bladder is filled with so-called white bile.

6. Subacute or chronic pancreatitis associated with cholecystitis, only after medical treatment shows no improvement and the condition grows worse.

7. Gangrenous gall-bladder, a condition which though hard to diagnose should always be thought of in recurring cases of colicky attacks, resulting in necrosis of the gall-bladder.

In conclusion, we wish to reiterate that medical management is preferable in most of the cases of gall-bladder disease, with the provisos listed above, because statistical data indicates the persistence of morbidity in patients with gall-bladder disease after approximately one-third of all operations upon the biliary tract, even though medical mismanagement contributes to these results.

846 South Twelfth Street

A LESSON FROM A DEATH CERTIFICATE

NUMBER TWELVE

Patient, nineteen years. After several hours of labor cervix was four fingers dilated, but head would not engage. Version attempted—uterus ruptured—cesarean—stillbirth.

Patient died a few days later.

Version is often dangerous.

A. W. BINGHAM, M.D.

THE MANAGEMENT OF NORMAL PREGNANCY—PRE-NATAL CARE

MATERNAL WELFARE ARTICLE NUMBER FORTY

By JAMES FRANCIS NORTON, M.D., F.A.C.S., Jersey City, N. J.
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Pregnancy is best thought of as comprising not an entirely physiological process. The borderline between health and disease is very indefinitely marked in pregnancy, and in many instances it requires but little to change a normal into an abnormal state. An early recognition of this change from normal to abnormal depends upon the close supervision of the pregnant woman by some competent observer. Much has been accomplished towards a reduction of maternal mortality by adequate pre-natal care.

Williams defined pre-natal care as "such supervision and care of the pregnant, parturient and puerperal woman as will enable her to pass through the dangers of pregnancy and labor with the least possible risk, to give birth to a living child, and to be discharged in such condition that she may be able to suckle it and thus afford it the greatest prospect of attaining maturity, as well as to fulfill her duties as mother and housewife with a minimal amount of invalidism".

It is roughly estimated that about 20,000 women die yearly in the United States from immediate and remote effects of pregnancy. The most frequent causes of death are those due to:

1. Infection.
2. The toxemic states.
3. Hemorrhage in pregnancy, labor, and puerperium.
4. Aggravation of antecedent disease; e. g., heart disease, tuberculosis, nephritis, etc.

Only by close and constant supervision of the pregnant, parturient, and puerperal woman can further reduction in the death rate be made.

The pregnant patient should be encouraged to register early, either for private care or clinic supervision. The one responsible for the care of these patients should outline to them a proper hygiene of pregnancy, and should supervise their conduct throughout their pregnancy.

At the first visit a detailed history should be obtained, with particular emphasis on antecedent diseases: scarlet fever, tuberculosis in the individual or in the family, and stigmata of rachitis; and should include a description of any abdominal operations, particularly if the genitalia have been involved. With multiparae, the previous pregnancies and labors and puerperal states should be gone into, especially from the angle of toxemia, long or difficult labors, stillbirths or neo-natal deaths.

Early, complete physical examination, looking particularly to heart disease, syphilis, tuberculosis, nephritis, and anaemia should be made, at which time haemoglobin determination, routine Wassermann, urine, and other indicated tests should be performed. Much can be done at this time to gain the confidence of the patient, and to disabuse her of any fear or apprehension.

Vaginal Examination. One should, in most instances, be able to conduct the ante-partum supervision of normal pregnancy with two vaginal examinations; the first should be done at the time of the first visit, at which time a positive diagnosis of pregnancy should be made, determining that the pregnancy is intra-uterine and not extra-uterine; that there is not a retro-displaced pregnant uterus; that there are no masses (ovarian cyst or fibroids) in the pelvis; and if possible, there should be an estimate of the diagonal conjugate, with palpation of the contour of the pelvis.

At the time of this first vaginal examination as accurate and as detailed a knowledge of the contour and size of the pelvis as it is possible to obtain should be made.

A general impression of the pelvic inlet should be obtained with particular reference to its anterior segment and then its posterior segment: the character and prominence, or lack of prominence, of the ischial spines; the length of the sacro-spinous ligaments and the character of the apex of the sacro-sciatic notch;

the contour, curvature, and inclination of the symphysis pubis; the character of sub-pubic angle and the shape of the sub-pubic arch.

The most important single observation is the length of the diagonal conjugate (C-D 12.5 cm.), and the technic of measuring it, estimating from this the true conjugate (C. V. 11 cm.); while the patient is still in lithotomy position, measure with pelvimeter the transverse diameter of the outlet (T. O. 8.5-9 cm.).

With the increased interest in the newer classifications of the pelvis based on configuration or morphology there has of late been a tendency to question the importance of external pelvimetry. This still yields some valuable information, particularly if one is dealing with a flattened external conjugate; again, if the interspinous diameter is equal to, or greater than, the intercrystal, one must think of rachitic pelvis.

Most of the problems of pre-natal care are concerned with the giving of advice and direction for the proper hygiene of pregnancy. It is important that the patient return at frequent stated intervals for supervision: about every three weeks for the first seven months, and thereafter every ten to fourteen days; this in the absence of any unusual or abnormal state; and at each visit the urine should be examined, the blood pressure taken, and the weight recorded, an abdominal examination made, questions answered, and advice given.

An abdominal examination is to be made to determine presentation and position of the fetus, and at the same time the fetal heart sounds should be listened to.

The patient should be encouraged to seek advice and to ask questions, and any guidance deemed necessary should be given. There are some questions which are so uniformly asked that it might be well to consider them in some detail.

Diet. If there exists no toxemia, and if there is no nausea or vomiting early in the pregnancy, and if the weight gain is not too rapid or excessive, there need be no great change in the diet. However, it is best that no alcohol be taken, because of its known irritation on the kidneys and liver. Because of the importance of calcium, and its need for both mother

and child, some provision should be made for assuring an adequate calcium supply. As a rule, one quart of skimmed or whole milk per day, or about one-half pound of cheese, will satisfy, with no additional supply of calcium, all the demands for calcium in a normal pregnancy.

The diet may be varied with different quantities of protein, fats, and carbohydrates. The other minerals beside calcium—iron, phosphorous, etc.—can be added to the diet if their need is indicated. A ready source of iron is beef liver, and it may be prescribed as such. Vitamin needs can usually be supplied from the milk previously mentioned, eggs, whole wheat cereals, vegetables, fruits, or cod-liver oil. Salt and highly spiced or seasoned foods and condiments should be either avoided altogether, or reduced to a minimum. Smoking should be reduced in amount; it is not, however, thought to be harmful in moderation.

Dress. Common-sense laws of dressing are to indicate the manner of dress. Corsets or girdles should be used if needed for support, especially so in multiparae with lax abdominal wall. Circular or constricting garters should be avoided because of interference with return venous flow, predisposing to varicose veins. A garter belt best serves the purpose.

Garments, on the whole, should be made to hang from the shoulder.

High-heeled shoes have too great a tendency to throw the body too far forward, and therefore make it difficult to maintain balance. The flat military heel is better, and holds the pelvis in better alignment.

Exercise. Regular, moderate exercise is not only desirable,—it is necessary. Walking is perhaps the safest. If there is a history of previous abortion, there should be definitely less going about on the days of expected menstrual periods. Any exercise undertaken should be stopped short of fatigue. Motor rides may be undertaken, provided the roads are even surfaced and the driver exercises caution. Golf and tennis should be closely supervised.

Bathing. Proper care of the skin is of decided importance, and bathing is therefore necessary—a tub bath or shower, according to the personal choice, except in the last month of

pregnancy, or if membranes are ruptured; then the tub bath should be avoided because of danger of infection. At all times, the patient should avoid excesses of temperature because of shock, and danger of instituting uterine contractions. At no time should the pregnant women bathe in a heavy surf.

Bowels. The most desirable situation would be a regular bowel movement every day without the aid of drugs, if possible. This may be accomplished by the ingestion of water, fruits, and vegetables; if other help is needed, enemas, suppositories, and mild laxatives, preferably cascara and milk of magnesia.

Teeth. Early dental consultation is indicated. All necessary work should be done early in pregnancy. A deficiency in vitamins C and D seems particularly related to dental caries, C deficiency occurring in dental decay. This vitamin is abundant in citrous fruits; while D, which seems to be associated with bone production, is supplied as a rule in the average diet. If not, the addition of one or two eggs will supply the deficiency.

Sleep. Abundance of sleep is important. The minimum of eight hours, and preferably ten hours a night, should be sought, with an hour of rest during the mid-afternoon.

Nervous System. If restlessness, anxiety, or sleeplessness manifest themselves, they should be controlled with mild sedatives. Bromides gr. 15, chloral gr. 5 two or three times a day and repeated at bedtime, are usually sufficient.

Backaches and Leg Pains. Backache is due mainly to the change in posture, with the ever-present attempt on the part of the patient to maintain her balance. Leg pains are most usually ascribed to pressure on the sciatic nerve from the presenting part in the pelvis.

Both of these complaints, as a rule, can be controlled with sodium salicylate, 10 or 15 gr. two or three times a day.

Traveling. It is not well to allow the patient to get too far away from direct, competent supervision because of the possibility of the occurrence of any of the emergencies associated with pregnancy—intercurrent diseases, hemorrhage, toxemia, premature labor, etc., etc.

Occupation. All arduous work should cease immediately. Those engaged in clerical work

and in teaching may frequently continue on to later in pregnancy without any deleterious effects.

Weight. Many authorities feel that sudden weight gains indicate a fluid retention long before the appearance of edema. Pitting is not an early sign of edema. Excessive weight gain in pregnancy, aside from its debatable or questionable importance as a factor producing dystocia through overgrowth of the fetus, is very important from its association with the toxemias. Normal weight gain throughout pregnancy is approximately twenty pounds; or if previously under weight, it may go to thirty pounds.

Sex Determination. It is not possible to foretell sex. Neither is it possible to influence the sex of the unborn child by diet, etc. The sex of the infant is determined very early in pregnancy, probably at the time of the fertilization of the egg, or very shortly thereafter.

Mental Hygiene. An attitude of equanimity should be striven for, and the idea of maternal impressions, fears, extraneous influences, etc., dispelled.

Fresh Air. The patient should spend a part of each day out in the open air, either walking or on a motor ride, avoiding excesses in temperature.

Marital Relations. Because of the very real danger of puerperal infection, there should be an absolute proscription regarding marital relations in the last six weeks of pregnancy. Repeated fatal cases of puerperal infection have all too frequently been definitely traced to this source.

Breasts. Care of the breasts; first, they should receive proper support, such as is afforded by an uplift type of brassiere; secondly, the nipples should receive special care during the latter half of pregnancy—cleanliness, and the application of some very mildly astringent solution. If the nipples are retracted, the patient should be instructed how to draw them out daily. This helps materially during the nursing period.

Pre-natal Visits. At each visit the urine should be examined, particularly for albumin and glucose, and a record kept of the findings. If either are present, acetone and diacetic acid

should be looked for. The blood pressure should be recorded at each visit, taking as normal a systolic of 140, and a diastolic of 90. The weight should be recorded, and also the complaints of the patient. The patient should be instructed to be on the lookout for the most common symptoms indicating toxemia of pregnancy.

Considerable time and difficulty will be saved by the use of a card or booklet enumerating simple instructions, as follows:

Send or bring a specimen of urine in a bottle with your name on it on the dates specified.

Drink if possible six glasses of water each day between meals.

Take regular exercise, as indicated.

See that the bowels move daily; report any inability in this direction.

Bathe the nipples night and morning from the sixth month onward with the solution prescribed.

Report: Any persistent headache; scanty urine; any disturbance of vision; any marked swelling of feet or face; any bleeding or escape of water; any pain with regular recurrences; or anything that is not as it should be.

Vaginal Examination Late in Pregnancy.

The most important examination, from an obstetrical standpoint, is the one that is to be made late in pregnancy, either very late in the eighth month, or very early in the ninth month. At this examination, one should carefully estimate the size of the pelvis and the relation of the fetal presenting part to the pelvic inlet, as also determine the presentation and position, and estimate the size of the fetus.

Do not allow the patient to go more than one week past her expected date of confinement without checking on the size of the fetus, and rechecking for cephalo-pelvic disproportion. At this late examination in pregnancy, a recheck of the general condition of the patient should be made, but most emphasis should be placed on the abdominal and vaginal examinations.

In making the abdominal examination to determine the presentation and position of fetus it is best to follow a set routine. With the abdomen bared, and the patient on a table,

the examiner should stand at right of table and first locate the fetal back and small parts.

Second, palpate the lower or presenting fetal pole.

Third, palpate the upper fetal pole. Locate and count fetal heart.

Do not allow the women to go into labor with an abnormal presentation if it is at all possible to correct it.

There then remains the final vaginal examination. In every detail the pelvis should be again checked in the same manner as indicated under first vaginal examination, and any discrepancy between the two examinations explained. Especially emphasize the diagonal conjugate (D. C.).

With the fetus at term, an idea of the relationship of the fetal presenting part to the pelvic inlet should be had; this can be approximated by means of Hillis impression, or Munro-Kerr maneuver.

Hillis Impression. With the vaginal or rectal finger against the presenting part, firm continuous pressure is exerted against the fundus uteri and the amount of descent of the presenting part noted. If the lowermost bony part of a moderately molded or unmolded head has reached a line drawn between the tips of the spines of the ischium, the biparietal diameter is then through the true conjugate.

Munro-Kerr Maneuver. With the index finger of the right hand in vagina, and the thumb externally over the symphysis pubis the presenting vertex is grasped with the left hand and its degree of impression, or lack of impression, is noted.

If nothing abnormal had developed throughout the pregnancy, if no abnormal presentation or position is found, and if there is an ample pelvis with no evidence of disproportion—nothing remains except to await the onset of labor.

Finally, it should be stressed that it is exceedingly important for the patient to return six weeks post-partum in order that any abnormalities found may be corrected; and further, that any pelvic and soft-part trauma incident to labor may be repaired, and the mobility, involution, and position of the uterus made certain.

STATE SOCIETY ACTIVITIES

BOARD OF TRUSTEES

Abstract of report of meeting on August 13, 1939.

A regular meeting of the Board of Trustees of The Medical Society of New Jersey was held on Sunday, August 13, 1939, at 11:20 a. m. in the Executive Offices, Trenton, New Jersey. Those present were: Drs. Hollinshed, Chairman, presiding; Hawkes, Morris, Lewis, Marsh, Stahl, Young, North, McBride, Costello, and Dr. Wilkes, Executive Officer.

Dr. Wilkes reported on the legislative status of A-676—Assembly Committee Substitute, which was introduced to correct an error in reference to osteopaths' licensure. This bill is now in the Assembly ready for vote, and we have the assurance of its passage in both houses of the legislature.

Dr. Wilkes was authorized to attend the meeting of the American Congress on Obstetrics and Gynecology in Cleveland during the week beginning September 11, 1939, in order to report the public health aspects of the proceedings.

The Trustees discussed the interpretation of the address of Mr. Samuel Turk, State Compensation Officer, to the House of Delegates, on June 7. (Transactions, pages 23 and 30.) The Trustees referred the suggestions to the Ways and Means Committee of the State Society for further study and report.

The Trustees discussed the problem as to which of the two State Departments—Health, or Institutions and Agencies—should have the distribution of Federal funds for public health work. It was decided to take no sides of the problem.

There was a discussion on the question whether or not osteopaths who had been licensed to practice medicine and surgery were eligible for membership in The Medical Society of New Jersey. The informal opinion was expressed that these osteopaths might be received as courtesy members.

The details of the Fall Clinical Conference were discussed.

The administration of the Medical Service Plan was brought up, and the services of Dr. Scott, Executive Assistant, and a stenographer were authorized for the benefit of the committee.

Drs. John F. Anderson, Chester I. Ulmer and R. L. Ballinger were appointed to repre-

sent The Medical Society of New Jersey in the meeting of the committee for the revision of the national pharmacopeia to be held this Fall.

Dr. Hawkes reported on the meeting of the Workmen's Compensation Committee on July 30, 1939. A sub-committee, consisting of Drs. Comando, Hawkes, Pollak, McBride and Morris was authorized to meet with Commissioner Toohey to discuss amendments to the Workmen's Compensation Act.

Plans were discussed for preparing reports of the meetings of the Trustees for publication.

A report on the problem of graduate education for Negro physicians was made by a committee consisting of Drs. Morris, Lewis and Marsh. New Jersey has a colored population of about 175,000, among whom about 150 colored physicians are practicing. The committee reported:

"This group has stood out against the Federal Health Plan because they suddenly realized that under it the welfare of their people would not be conserved.

"In our State the Colored Physicians have not only amply demonstrated their zeal and devotion to the health problems of their race, but occupy important positions in health departments, and are considered to be well qualified for public health work. If this be true, they are worthy of the best traditions of American Medicine, and should be granted hospital privileges.

"Because of the fact that the united strength of all the professions engaged in the Practice of Medicine should present a program for the solution of the problem of the health of all the population, it would seem that The Medical Society of New Jersey should give this matter further study and plan to make some definite recommendations to the House of Delegates at the next Annual Convention.

"Inasmuch as the Negro problem in New Jersey resolves itself into the provision of post-graduate clinical training and experience for the Negro physicians, and inasmuch as such training revolves around our hospitals, it would seem that this matter should be referred to the Hospital Relationships Committee for further study."

Dr. Costello moved that Dr. Morris' report on the Negro problem be referred to the Hospital Relationships Committee for further study. Seconded by Dr. Young and carried.

Dr. Morris read a news note from the New York Herald Tribune of August 13, 1939, page 24, regarding a Health Forum to be conducted by the Tribune in the Fall. Dr. Stahl was instructed to offer the coöperation of the Medical Society to the Forum.

The question of the definite relations of the Hospital Service Plan to ward patients was discussed by Dr. Herrman. The problem was referred to the Hospital Relationships Committee for investigation and suggestions.

Dr. Hawkes reported that Essex County had called to his attention that certain county

societies in the State required citizenship before physicians could become a member of the Society. The desire expressed by the Essex County Medical Society is that every physician who is licensed in New Jersey and who has registered in some county should be eligible in that county medical society. Several counties requiring the citizenship requirement should be requested to withdraw this stipulation.

Dr. Lewis made a motion that the matter of citizenship be referred to the Welfare Committee. Seconded and unanimously carried.

AWARDS OF MERIT

It is the policy of The Medical Society of New Jersey to make a tangible recognition of outstanding accomplishments of its members. The Transactions of the 1939 session of the House of Delegates, page 17, record the presentation of bronze plaques to four of its devoted members.

The plaques are of a uniform design which is shown in the accompanying illustration representing one of the plaques at about half-size. The upper part bears the seal of the Society in relief. The part which bears the inscription is of polished bronze in which the letters are incised. The plaque was photographed in such a way that each letter of the incised inscription stands out clearly, while some of the details of the seal, which is cast in relief, are obscure. However, the illustration brings out the beauty and significance of the plaque as a whole.

The die for the seal is prepared in such a way that future plaques may be made from it at a nominal price.



AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 6, 1940, at 2:00 p. m. The Board announces that it will hold only one Group B, Part I, examination this year prior to the final general examination (Part II), instead of two as in former years. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held in June, 1940.

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 4, 1939.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will

be conducted by the entire Board, meeting in Atlantic City, N. J., on June 8, 9, 10, and 11, 1940, immediately prior to the annual meeting of the American Medical Association in New York City.

Applications for admission to Group A, Part II, examinations must be on file in the Secretary's office not later than March 15, 1940.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I examinations (written paper and case records), and the Part II examinations (pathological and oral).

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

SOCIETY REPORTS

DATES OF MEETINGS OF COUNTY MEDICAL SOCIETIES OF NEW JERSEY

September, 1939—July, 1940

County	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July
Atlantic		13	10	8	12	9	8	12	10		
Bergen	12	10	14	12	9	13	12	9	14	11	
Burlington	14	12	9	14	11	8	14	11	9		
Camden		3	7	5	2	6	5	2	7		
Cape May		3						2			
Cumberland		10		12		13		9		11	
Essex		12	9	14	11	8	14	11	9		
Gloucester	21	19	16	21	18	15	21	18	16		
Hudson		3	7	5	2	6	5	2	7		
Hunterdon		24			23			30			25
Mercer		11	8	13	10	14	13	10	8	12	
Middlesex		18	15	20	17	21	20	17	15	19	
Monmouth		25	22	27	24	28	27	24	22	26	
Morris		19	16	21	18	15	21	18	16	20	
Ocean		11	8	13	10	14	13	10	8		
Passaic	14	12	9	14	11	8	14	11	9		
Salem	8	13	10	8	12	9	8	12	10		
Somerset		12	9	14	11	8	14	11	9	13	
Sussex									14		
Union	13		8		10		13	10	8		
Warren		17			16			16			16

DATES OF MEETINGS OF COUNTY MEDICAL SOCIETIES OF NEW JERSEY SEPTEMBER, 1939—JULY, 1940

SEPTEMBER, 1939		MARCH, 1940	
8 Salem	14 Burlington	5 Camden	14 Burlington
12 Bergen	14 Passaic	5 Hudson	14 Essex
13 Union	21 Gloucester	8 Atlantic	14 Passaic
		8 Salem	14 Somerset
OCTOBER, 1939		12 Bergen	20 Middlesex
3 Camden	12 Somerset	13 Mercer	21 Gloucester
3 Cape May	13 Atlantic	13 Ocean	21 Morris
3 Hudson	13 Salem	13 Union	27 Monmouth
10 Bergen	17 Warren		
10 Cumberland	18 Middlesex	APRIL, 1940	
11 Mercer	19 Gloucester	2 Camden	11 Passaic
11 Ocean	19 Morris	2 Cape May	11 Somerset
12 Burlington	24 Hunterdon	2 Hudson	12 Atlantic
12 Essex	25 Monmouth	9 Bergen	12 Salem
12 Passaic		9 Cumberland	16 Warren
		10 Mercer	17 Middlesex
NOVEMBER, 1939		10 Ocean	18 Gloucester
7 Camden	9 Somerset	10 Union	18 Morris
7 Hudson	10 Atlantic	11 Burlington	24 Monmouth
8 Mercer	10 Salem	11 Essex	30 Hunterdon
8 Ocean	14 Bergen		
8 Union	15 Middlesex	MAY, 1940	
9 Burlington	16 Gloucester	7 Camden	10 Atlantic
9 Essex	16 Morris	7 Hudson	10 Salem
9 Passaic	22 Monmouth	8 Mercer	14 Bergen
		8 Ocean	14 Sussex
DECEMBER, 1939		8 Union	15 Middlesex
5 Camden	14 Burlington	9 Burlington	16 Gloucester
5 Hudson	14 Essex	9 Essex	16 Morris
8 Atlantic	14 Passaic	9 Passaic	22 Monmouth
8 Salem	14 Somerset	9 Somerset	
12 Bergen	20 Middlesex		
12 Cumberland	21 Gloucester	JUNE, 1940	
13 Mercer	21 Morris	11 Bergen	19 Middlesex
13 Ocean	27 Monmouth	11 Cumberland	20 Morris
		12 Mercer	26 Monmouth
JANUARY, 1940		13 Somerset	
2 Camden	11 Somerset		
2 Hudson	12 Atlantic	JULY, 1940	
9 Bergen	12 Salem	16 Warren	25 Hunterdon
10 Mercer	16 Warren		
10 Ocean	17 Middlesex		
10 Union	18 Gloucester		
11 Burlington	18 Morris		
11 Essex	23 Hunterdon		
11 Passaic	24 Monmouth		
FEBRUARY, 1940			
6 Camden	13 Bergen		
6 Hudson	13 Cumberland		
8 Burlington	14 Mercer		
8 Essex	14 Ocean		
8 Passaic	15 Gloucester		
8 Somerset	15 Morris		
9 Atlantic	21 Middlesex		
9 Salem	28 Monmouth		

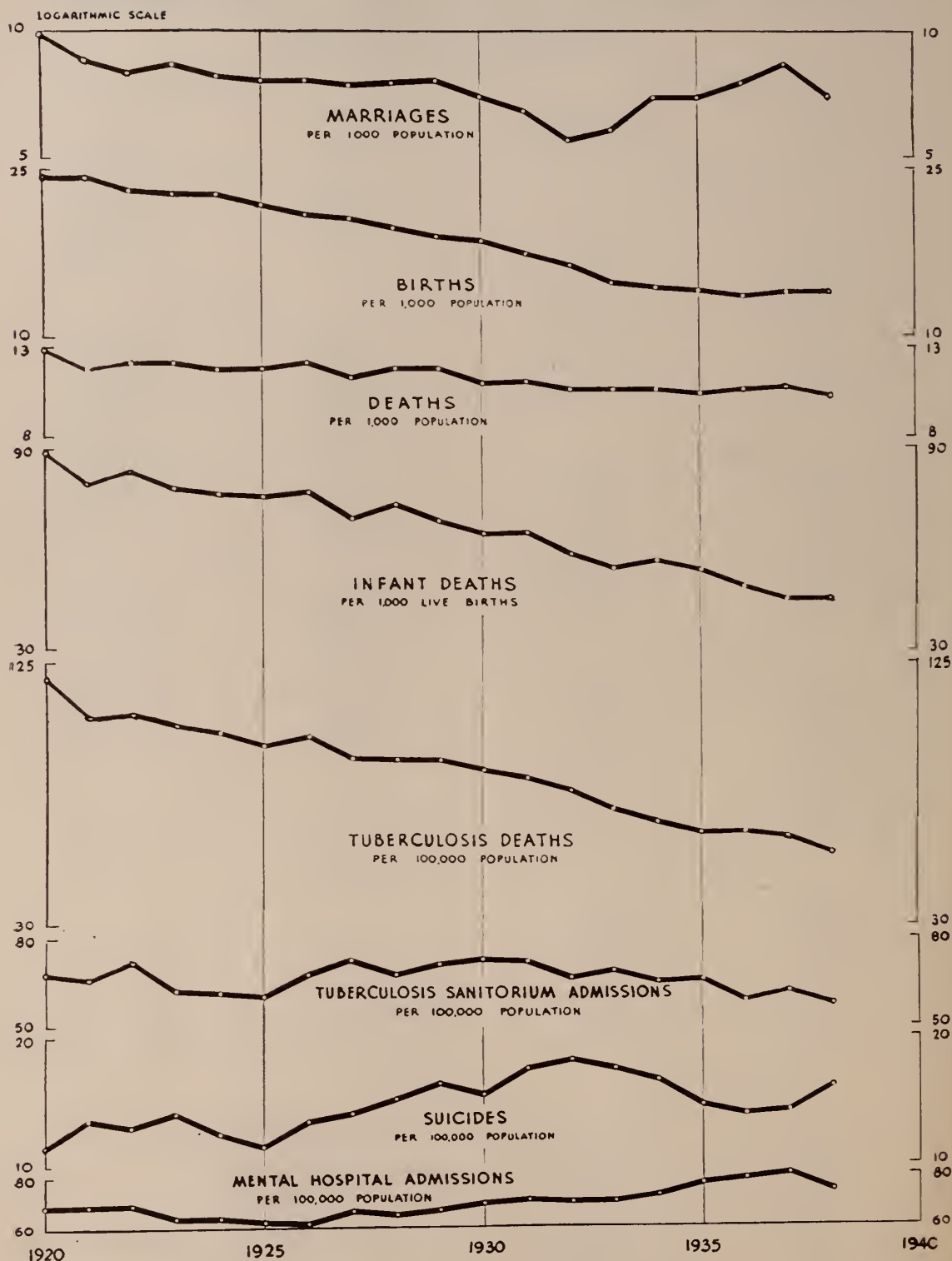
Cape May has two other meetings at the call of the President.

Sussex County, besides its annual meeting on May 14, holds other meetings at the call of the President.

SEPTEMBER, 1938, TO JULY, 1939

Number of meetings scheduled	147
Number of meetings reported	107
Percentage reported—73	

Strive to exceed this percentage during the
current year.



TRENDS OF VITAL STATISTICS

See chart on page 562.

The chart on page 562, covering two decades, was prepared by Dr. Emil Frankel, Statistician of the Department of Institutions and Agencies of the State of New Jersey. It is a graphic representation of certain trends in human action and conditions which affect life and health of the State of New Jersey, as distinguished from its individual inhabitants.

The number of marriages declined up to 1932, and then increased until 1937, and again declined in 1938.

Births have shown a decline to half the rate of 1920, but the deaths also showed a corre-

sponding decline. Will senility, instead of virile youth, characterize the next generation? There is hope in the fact that an infant born today is reared under conditions that are favorable to vigor of body, mind, and soul.

Tuberculosis deaths are less than half of their number a score of years ago; but sanatorium admissions remain about the same, for more and more patients are entering them in order to learn how to live, and not to die.

Mental hospital admissions are also increasing, but one reason is that patients enter them voluntarily in order to be cured, rather than imprisoned.

THE COMMITTEE ON PUBLIC RELATIONS

By JOSEPH H. KLER, M.D., Chairman, New Brunswick, N. J.

The objective of the Committee on Public Relations during the coming year will be to inform the people how they can secure the greatest benefit from the health and medical services which are offered to them by practicing physicians.

The committee will use the following means to attain its objective:

1. Press releases providing news of organized medicine in New Jersey and other information relevant to health and medical care.

2. Continued sending of the weekly health feature, "The M.D. Says:", to the press.

3. Distribution to legislators and mailing list of material pertaining to work of the Society.

4. Promotion of a third anti-appendicitis campaign.

5. Use of exhibits.

6. Securing radio time for special occa-

sions and promotions of a Society radio program if feasible.

7. Continued service to physicians in providing speakers' service loan material.

8. Continuation of the function of the committee as a service agency by assisting county medical societies in the preparation of publicity.

9. Continued contact with the press and with organizations interested in health.

10. Promotion of paid institutional advertising by county medical societies.

11. A meeting of the State Society's Public Relations Committee with chairmen of county medical society public relations committees in order to coördinate and clarify public relations policies of the State and county societies.

12. Preparation and distribution to physicians of information pertaining to medical economics.

REFRESHER COURSES IN SYPHILIS

Two refresher courses in syphilis are offered by the New Jersey State Department of Health, in coöperation with the United States Public Health Service. Each course will consist of six lectures and demonstrations.

One course will be given in the University of Pennsylvania, by Dr. John H. Stokes and his staff, on Wednesdays from November 15 to December 20, 1939, starting at 9:30 a. m. with an afternoon session. This class is limited to sixteen members.

A similar course will be given in the Orange Memorial Hospital, on Wednesdays from October 25 to November 29, from 10 a. m. to 3 p. m. This course is limited to sixty members.

The courses are free, and are open to any practicing physician of New Jersey; but preference will be given to physicians who are working in venereal disease clinics in New Jersey.

Application for either course should be made to the State Department of Health, Trenton.

SUDDEN ILLNESS OF AUTOMOBILE DRIVERS

Dr. Norman M. Scott, Executive Assistant, has sent out the following letter to the President and the Secretary of each County Medical Society regarding an investigation into conditions whose sudden onset incapacitates drivers of automobiles:

Dear Doctor:

Through our Committee on Traffic Accidents we are coöperating with the State Commissioner of Motor Vehicles in the investigation of sudden deaths and illnesses of persons driving automobiles.

The purpose of this investigation is to determine which types of persons are potential hazards to themselves or others while driving a car.

The cases are so scattered that a personal investigation by the Executive Office staff is time-consuming and expensive.

We are asking your coöperation as President of your County Medical Society in the investigation of cases within your county. Perhaps you can assign cases referred to you to some of the younger members of your society who would be interested in this type of investigation.

This is work we have obligated ourselves to

do, and your coöperation will be appreciated.

There are at present about twenty cases in which the investigation is incomplete. Cases that have occurred in your county will be referred to you in the near future.

In general, the following questions should be answered as they apply to individual cases:

1. Did the case involve an accident?
2. Did death occur prior to the accident?
3. Was the accident a contributing cause of injury or death?
4. Was the accident the result of the driver's illness?
5. Were other persons injured?
6. What was the cause of death?
7. If the case did not involve the death of the driver, what was the diagnosis of the illness?
8. Would, in your opinion, a physical examination at the time the license was issued have revealed the diagnosis?
9. Would the physical examination have revealed sufficient evidence to warrant a refusal of license on the basis that the driver might constitute a hazard to himself or others?
10. Should this driver have been denied a license on the basis of a known physical defect?

PRE-NATAL BLOOD TESTS

The law of New Jersey requires that a blood test for syphilis shall be made on every pregnant woman during pregnancy or at delivery.

The person reporting a birth shall state on the birth certificate whether or not the blood test was made, and the date. Dr. Lynn Mahaffey, Director of Health of the New Jersey Department of Health, writes as follows:

"In checking over the birth certificates filed in our Bureau of Vital Statistics for the month of May, it was discovered that only 69 per cent carried statements about whether or not the blood tests for syphilis had been made during pregnancy, as required by the law. Some of this deficiency is possibly due to the fact that the new certificates with the spaces provided for this information have not yet reached physicians. These forms are available from this Department and local registrars of vital statistics, and we are hoping that the old ones will be discarded and the new ones universally used.

"From the May birth certificates mentioned above, it was also discovered that only 20 per cent of those which carried the information

about the prenatal blood tests indicated that tests had been made prior to the fifth month of pregnancy. If the objectives of the law are to be reached, it is of great importance that physicians and women understand the importance of early tests so that treatment can do the most good. Perhaps you will be willing to emphasize this point also in your Journal."

The law is as follows:

1. Every physician attending pregnant women in the State for conditions relating to their pregnancy during the period of gestation and/or at delivery shall, in the case of every woman so attended, take or cause to be taken a sample of blood of such woman at the time of first examination and shall submit such sample to an approved laboratory for a standard serological test for syphilis. Every other person permitted by law to attend pregnant women in the State, but not permitted by law to take blood samples, shall cause a sample of blood of such pregnant women to be taken by a physician duly licensed to practice medicine and surgery and have such sample submitted to an approved laboratory for a standard serological test for syphilis.

2. For the purpose of this act a standard serological test shall be a test for syphilis approved by the Director of Health of New Jersey, and shall be made at a laboratory approved to make such tests by the Director of Health of New Jersey. Such laboratory tests as are required by this act shall be made on request without charge at the Department of Health of the State of New Jersey.

3. In reporting every birth and stillbirth, physicians and others required to make such reports shall state on the certificate whether a blood test for syphilis has been made upon a specimen of

blood taken from the woman who bore the child for which a birth or stillbirth certificate is filed and the approximate date when the specimen is taken.

4. The sum of fifteen thousand dollars (\$15,000.00), or so much thereof as may be necessary, is hereby appropriated to the State Department of Health to cover the additional clerical printing and other expenses in carrying out the provisions of this act.

5. This act shall take effect January first, one thousand nine hundred and thirty-nine.

DR. FRANCIS ASBURY APGAR

The Hunterdon County Democrat of July 27 contains a portrait and appreciation of Dr. Francis Asbury Apgar, in honor of the 88th anniversary of his birth, which occurred on July 23, 1851. He is the son of a farmer in Oldwick, in the northeastern section of Hunterdon County. He graduated from Bellevue Medical School in 1876, and has practiced in his home town ever since. He still keeps office hours, and prescribes for patients.

On July 27, 1937, Dr. Apgar was honored by the Hunterdon County Medical Society with a golden key for sixty-one years of practice. At the same time two other members were similarly honored for over fifty years of practice,—Dr. Harry M. Harman, Frenchtown, and Dr. Edward W. Closson, of Lambertville. An expressive photograph of Drs. Apgar and Closson taken on the day of the presentation was printed in The Journal of August, 1937, page 537.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

As there are no regular monthly meetings during the summer, the Council meets at the call of the President, Dr. Royal Schaaf, and transacts such business of the Society which is necessary.

Dr. Royal A. Schaaf, the President, has appointed all the chairmen and members of committees for the ensuing year. If you wish to serve on any special committee, let your wishes be made known.

Dr. Edward Sprague has been hard at work on the Insurance Plan. It will be found in another section of this issue. Read it over.

The Officers and Council of the Essex County Medical Society entertained the legislators of Essex County at an informal dinner at the Essex County Country Club on Thursday, July 20th. There were about thirty-five present.

Council Thursday, Oct. 5

Medicine and Pediatrics Tuesday, Oct. 10

Symposium on Recent Advances in Cardiology

a. The Fourth Lead

Aaron E. Parsonnet, M.D.

b. Treatment of Congestive Heart Failure

Francis C. Weber, M.D.

c. Treatment of Coronary Disease

Frederick A. Alling, M.D.

d. Cardiograms in Early Diagnosis of Heart Disease in Children (illustrated)

Henry C. Crossfield, M.D.

All papers limited to fifteen minutes.

Stated Meeting Thursday, Oct. 19

(Subject to be announced later.)

Surgery Tuesday, Oct. 24

(Subject to be announced later.)

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The Academy of Medicine of Northern New Jersey will begin its twenty-ninth season on October 2nd, with a clinical meeting of the Eye, Ear, Nose, and Throat Section at the Newark Eye and Ear Infirmary. This is one week earlier than usual due to the meeting of the Academy of Otolaryngology, held in Chicago, October 9th.

PROGRAM FOR OCTOBER, 1939

Eye, Ear, Nose and Throat Section—Clinical meeting, Newark Eye and Ear Infirmary, 77

Central Avenue, Newark..... Monday, Oct. 2

HUNTERDON COUNTY

Arthur M. Jenkins, M.D., Reporter

The regular meeting of the Hunterdon County Medical Society was held in Glen Gardner at the New Jersey Sanatorium for Tuberculous Diseases on July 25. Dr. J. J. Cartisser, newly elected President, presided over nineteen members present.

Dr. Marsh, Second Vice-President of the State Medical Society, outlined the objectives of the State organization as suggested by Dr. E. Z. Hawkes, State President.

The Staff of the Sanatorium presented an interesting program on the differential diagnosis of tuberculous and nontuberculous pulmonary diseases, with case reports and x-rays.

SOMERSET COUNTY

H. F. Day, M.D., Reporter

The 123rd Annual Meeting of the *Somerset County Medical Society* was held at the Nurses' Home of the Somerset Hospital on June 8, 1939.

The Treasurer reported fifty-seven paid-up members.

The following officers and delegates were elected:

President, A. W. Piggott
Vice-President, L. C. Fritts
Treasurer, A. A. Lawton
Secretary, D. O. Hamblin
Reporter, H. F. Day

NUMBER OF CHILDREN REPORTED AS RECEIVING FREE STATE BIOLOGICS SINCE JULY 1, 1938

DIPHTHERIA TOXOID

County	Total to May 31	Month of June	Total to June 30	Average per Month
Atlantic	777	105	882	73.5
Bergen	3742	1044	4786	398.8
Burlington	737	215	952	79.3
Camden	5838	905	6743	561.9
Cape May	375	74	449	37.4
Cumberland	325	25	350	29.1
Essex	10706	1247	11953	996.1
Gloucester	739	91	830	69.1
Hudson	4793	395	5188	432.3
Hunterdon	538	60	598	49.8
Mercer	2584	67	2651	220.9
Middlesex	1051	57	1108	92.3
Monmouth	340	9	349	29.1
Morris	647	115	762	63.5
Ocean	230	0	230	19.1
Passaic	2905	1702	4607	383.9
Salem	327	22	349	29.1
Somerset	172	1	173	14.4
Sussex	5	107	112	9.3
Union	2860	309	3169	264.1
Warren	475	25	500	21.6
Totals	40166	6575	46741	3895.1

SMALLPOX VACCINE

County	Total to May 31	Month of June	Total to June 30	Average per Month
Atlantic	550	14	564	47.
Bergen	2703	1118	3821	318.3
Burlington	313	31	344	28.6
Camden	2303	123	2426	202.1
Cape May	385	9	394	32.8
Cumberland	237	40	277	23.1
Essex	4513	682	5195	432.9
Gloucester	441	17	458	38.1
Hudson	3174	344	3518	293.1
Hunterdon	22	30	52	4.3
Mercer	1133	213	1346	112.1
Middlesex	1790	64	1854	154.5
Monmouth	1092	189	1281	106.7
Morris	849	23	872	72.6
Ocean	102	119	221	18.4
Passaic	1959	614	2573	214.5
Salem	411	14	425	35.4
Somerset	1193	8	1201	100.1
Sussex	2	2	4	.3
Union	1277	178	1455	121.2
Warren	222	42	264	22.
Totals	24671	3874	28545	2378.7

JULY IMMUNIZATIONS

Counties	Immunizations	Vaccinations	Middlesex	13	19
Atlantic	14	0	Monmouth	501	83
Bergen	333	473	Morris	139	165
Burlington	8	34	Ocean	0	18
Camden	572	83	Passaic	604	317
Cape May	20	20	Salem	3	7
Cumberland	6	13	Somerset	18	145
Essex	1067	721	Sussex	0	0
Gloucester	37	37	Union	231	226
Hudson	165	335	Warren	2	14
Hunterdon	0	7	Totals	3733	2717
Mercer	0	0			

BOOK REVIEW

BAPTISM OF THE INFANT AND THE FETUS: AN OUTLINE FOR THE USE OF DOCTORS AND NURSES. By the Reverend J. R. Bowen, Chaplain, St. Joseph Mercy Hospital, Dubuque, Iowa. Paper. 25 cents. Pp. 12. Dubuque: M. J. Knippel Company, 1935.

This booklet is designed to provide doctors and nurses with information regarding their duty to administer the rite of baptism to an infant in an emergency during the process of its birth, when the service of a priest is not available. The foreword states:

"The priest entrusted with the care of souls is strictly obligated to extend to all the opportunity of receiving Baptism. That he may adequately dis-

charge this duty, he must in many instances seek the kindly coöperation of doctors and nurses, Catholic and non-Catholic. Indeed, it has long been the charitable practice of non-Catholic doctors and nurses to baptize in case of necessity the babies of Catholic parents—a service which not only brings the privileges of Baptism to the little ones, but also affords inestimable consolation to the parents."

Directions, brief and specific, are given for administering the rite, particularly to an unborn child; and conditions when the rite should be administered are enumerated. Since it is the duty of every physician to offer consolation to his patient in every emergency, he will find the booklet of inestimable value.

OBITUARIES

WILLIAM FREILE

Dr. William Freile of 25 Tonnele Avenue, Jersey City, New Jersey, died at his home on Monday, July 3, 1939, at 9:15 a.m. from congestive heart failure.

Dr. Freile was born in Ireland in 1874, but resided in Jersey City since boyhood. He received his degree of Doctor of Medicine at the Bellevue Hospital Medical College in New York, in 1898. He was Chief Surgeon in Christ Hospital, and did outstanding service in the World War.

He was a member of the American College of

Surgeons, the American Medical Association, The Medical Society of New Jersey and the Hudson County Medical Society. Dr. Freile was a former President of the Hudson County Medical Society, serving in 1926-1927. He also served as Reporter for the County Society from 1912 to 1916, and from 1918 to 1925.

He is survived by his wife, Mrs. Wilhelmina Freile; a daughter, Mrs. Doris Benedict; three sisters, Dr. Eva Freile of Jersey City, Miss Tenie Freile, and Mrs. Martha Peters; and a brother, Dr. Hugh Freile, a pharmacist.

LEVINGS A. OPDYKE

Dr. Levings A. Opdyke, of 55 Clinton Avenue, Jersey City, New Jersey, died at his home on Thursday, July 6, 1939, at 1:00 a.m., from an acute exacerbation of a chronic endocarditis, and a blood stream infection.

Dr. Opdyke was born in Clinton, New Jersey, in September, 1861. He was a graduate of the New Jersey State Normal School, and received his medical degree from the New York Homeopathic Medical College in 1885.

He was a member of the American Medical As-

sociation, The Medical Society of New Jersey, and the Hudson County Medical Society. He was also a member of the Bergen Lodge No. 47, F. & A. M.; Valley of Jersey City, Scottish Rite; Salaam Temple, A. A. O. N. M. S.; and the Holland Society.

Surviving are his widow, Mrs. Grace Wilson Opdyke; two daughters, Mrs. Thomas H. Brown, Mrs. Louise B. Daumont; a brother, Dr. George H. Opdyke, of West Hartford, Conn.; and a sister, Dr. Florence Opdyke, of Maine. Another brother, Dr. Charles T. Opdyke, of Verona, died some years ago.

FLOYD A. THOMAS

Dr. Floyd Ashley Thomas, for 32 years a practicing physician in Flemington, died in his home on August 9, 1939, aged 59 years, from coronary thrombosis.

Dr. Thomas was born in Easton, Pa., November 15, 1882, the son of the editor of one of the Easton newspapers. He graduated from Lafayette College in his native town in 1904, and from the University of Pennsylvania Medical School in 1907. He had practiced in Flemington ever since he received his doctor's degree.

For thirty years he was school physician in Flemington; and this year the students dedicated their school year book to him. He served at Camp McClelland during the World War, and was first President of the Flemington Legion.

Dr. Thomas was an active member of the Hunterdon County Medical Society, and served on the Flemington Board of Health. His photograph is number 18 in the group picture of the Hunterdon County Medical Society printed on page 537 of this Journal of August 1937.

DECEASED PHYSICIANS—NEW JERSEY

Data Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Deaths
Lewis W. Allen	67	June 13, 1939	Tenafly	Same	Coronary thrombosis.
Arthur H. Dundon	62	June 20, 1939	N. Plainfield	Same	Chronic articular rheumatism.
James M. Hackett	75	June 13, 1939	Leonia	Same	Cerebral hemorrhage.
Edward O. Schaaf	69	June 25, 1939	Newark	Newark	Diverticulitis of colon.
Ellsmore Stites	72	June 1, 1939	Bridgeton	Same	Chronic nephritis.
Louis J. Ferenczi	48	July 18, 1938	Bayonne	Bayonne	Carotid aneurysm.
William Freile	65	July 3, 1939	Jersey City	Same	Coronary sclerosis.
Sidney C. Keller	57	July 7, 1939	Loch Arbor	Newark	Coronary occlusion.
Howard M. Morton	71	July 19, 1939	Vincentown	Same	Hodgkins disease.
Levings A. Opdyke	78	July 6, 1939	Jersey City	Same	Chronic endocarditis.
Louis Reich	58	July 13, 1939	Newark	Same	Cerebral hemorrhage.
Joseph T. Welch	72	July 23, 1939	Long Branch	Same	Carcinoma of breast.

MESSAGE FROM THE PRESIDENT OF THE WOMAN'S AUXILIARY

MRS. G. E. McDONNEL

Auxiliary Members:

Greetings:

Another year's work is upon us. Let us strive faithfully to do our individual parts to make this Auxiliary year successful.

Stand back of your County Presidents and take part in whatever way you can,—a united group makes for strength.

Try to increase your membership. There are still far too many eligible women outside our ranks. Make it your business to get the new doctor's wife out to Auxiliary meetings.

Become an active member, and take part in the Women's Clubs and Parent-Teacher Associations of your community,—especially those interested in health.

Read the suggested books on the approved list, and ask for them at the county libraries.

If your county does not have an organized Auxiliary, find out why.

Let us become actively interested in public relations work by becoming well-informed ourselves.

All of the counties have interesting programs. Look for them in *The Journal* each month, and see for yourself what an Auxiliary can do.

An invitation is here given to all Auxiliary members to attend the first fall luncheon meeting of the State Board at the Walt Whitman Hotel in Camden on October 9th at 1:00 p. m. The guest of honor will be our National President, Mrs. Rollo K. Packard, of Chicago, Illinois. Also Dr. Hawkes, or Wilkes will represent the Medical Society.

MRS. G. E. McDONNEL, *President*.

PROJECTS FOR THE WOMAN'S AUXILIARY

(An editorial)

When each new group of officers of the Auxiliary assume their duties they have the opportunity to outline a set of objectives to be attained during the nine working months of the year. There are two groups of objectives which are usually announced:

1. There are the social events in which the members themselves are interested. These are worthy of special effort, for the first activity of any organization is to bring the members together in intimate companionship. Then when the members are acquainted with one another, they discover their various preferences and abilities and are able to appoint the committee members who are best adapted to their particular assignment. The members of the Auxiliary need little advice along social lines; on the contrary, they are the natural advisers of the members of their medical society.

2. There are medical society activities in which the Auxiliary can be of essential assistance. One line of work is the public relations of the medical society. Every town has organizations with frequent programs of civic, social, and educational nature. The Auxiliary can be of essential assistance to these organizations in securing the assignment of local physicians as speakers on medical subjects.

Such assignments are of benefit to the organizations, to the medical society, and to the Auxiliary.

A second opportunity is that of securing data on local medical history, particularly a record of the lives of present-day physicians. At least four Auxiliaries have collected histories of their past officers and bound them in volumes with loose-leaf binders which were shown in the exhibit at the Annual Meeting.

As the members become proficient in biographical research, they can collect the records of the lives of former doctors who still live in the memories of the older people.

A third opportunity is that of assisting the officers of their medical society in their projects. The State Society has an advisory committee to the Auxiliary. The members of these committees have hesitated to suggest lines of work for the Auxiliary; but the leaders of the Auxiliary will find them ready to give advice regarding any project which the Auxiliary is considering. If the advisory committee on the Auxiliary does not suggest lines of work in which women can assist the doctors, go to the chairman with a definite proposition and ask for his advice regarding the method of carrying it out. The Auxiliary has the opportunity to be of essential assistance to the doctors.

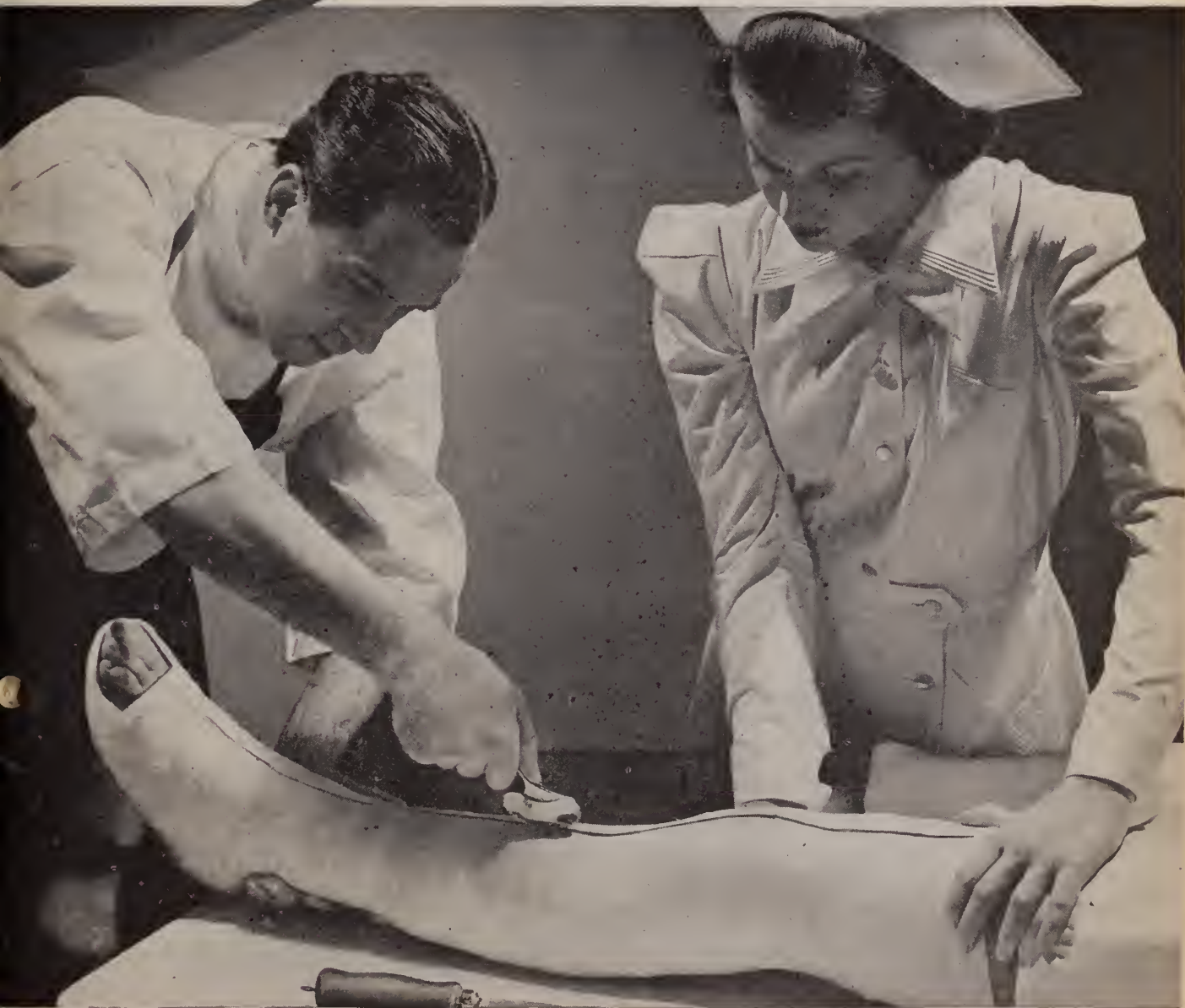
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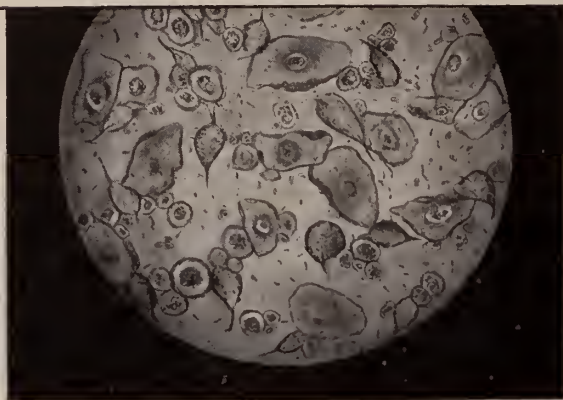
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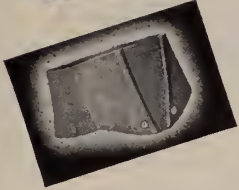
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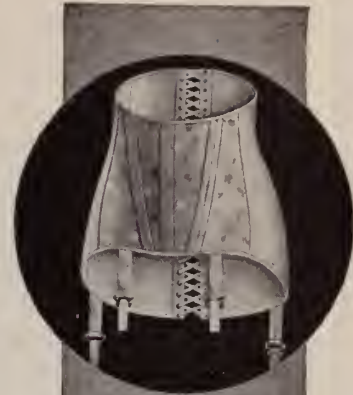


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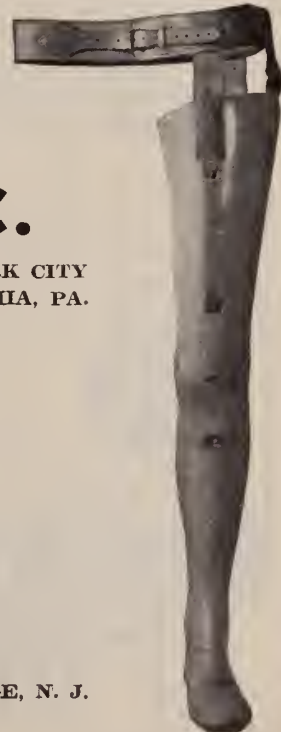
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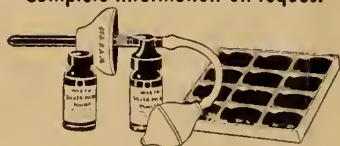
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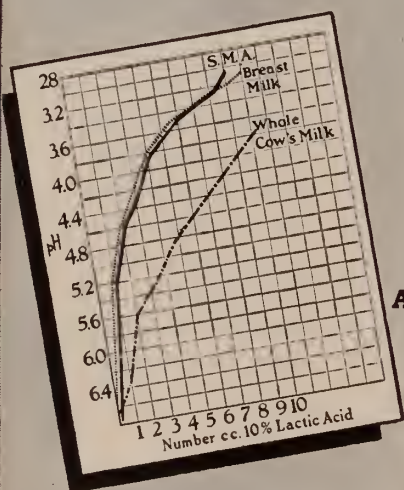
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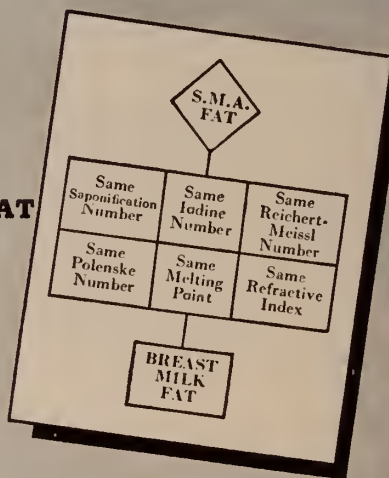
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ASH.....	0.25-0.30%	0.215-0.226
pH.....	6.8-7.0	6.97
Δ.....	0.56-0.61	0.56
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METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

1. The Determination of Vitamin D Activity

● About fifteen years ago it was clearly established that there could be present in certain foods or biological materials some substance which possessed antirachitic potency. Subsequently this "antirachitic factor" became known as vitamin D. Today, we know that at least ten sterol derivatives may exert antirachitic effects closely comparable to those of the originally discovered vitamin D (1).

Recognition of the existence of the antirachitic vitamin naturally stimulated investigation of methods whereby this dietary essential could be quantitatively estimated. Steady advances in knowledge of the causes and effects of rickets brought gradual improvements in these methods. Consequently, there are now available several techniques for the quantitative determination of vitamin D in foods or other biological materials.

The first and probably most widely employed method for estimation of vitamin D is by means of the so-called "line test" (2). In this technique as now employed (3), young rats are confined for 18 to 25 days to a diet conducive to development of rickets. These periods of time, with proper handling and confinement of the animals, are sufficient to induce a definitely rachitic condition. The rachitic rats are then properly grouped with respect to negative control groups to receive no supplements to the rachitic ration; positive control or reference groups to receive graded doses of some standard reference material; and "assay groups" to be given graded doses of the material under test. For the next 8 days the animals are fed daily doses of the proper supplement, either assay or reference material. No supplements are fed on the ninth and tenth days.

On the eleventh day the animals are sacrificed and either the proximal end of the tibia or the distal end of the radius or ulna dissected out, sectioned, cleaned and finally

immersed in silver nitrate solution. By double decomposition reaction, silver salts deposit where calcium is present in the metaphysis of the bone. When exposed to light these silver salts are reduced and form a dark line indicating the extent of calcium deposition. The experienced technician can estimate the degree of healing from rickets by the continuity and area of the line. By comparison of the results obtained on the various groups of animals, a quantitative expression of the antirachitic activity of the material under assay may be obtained.

A second method for evaluating vitamin D activity is that involving determination of "bone ash" (4). In this technique, final estimation of the degree of bone calcification—and thus the antirachitic potency of the substance under assay—is made by chemical analysis of specific bones of the experimental animals. A third assay method (5) is that involving roentgenological examination of certain bones. Comparisons of the bone densities of the various experimental animals serve as a basis for estimating the degree of healing from—or prevention of—rickets and hence permit determination of the vitamin D activity of the material under test.

Common foods as they naturally occur can hardly be considered as food sources of vitamin D. However, as exceptions, certain foods of marine origin (6) might be mentioned which consistently contribute small but definite amounts of the antirachitic factor to the diet. In addition, development of various means of fortifying foods with vitamin D—particularly those foods of importance in infant and child feeding—has made available other food sources of the vitamin (7). Among the many varieties of commercially canned foods will be found products of both types, which, when properly used or supplemented, should prove of value in obtaining an adequate intake of vitamin D, particularly by infants and children.

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(1) 1938. J. Am. Med. Assoc. 110, 2150.

(2) 1922. J. Biol. Chem. 51, 41.

(3) 1936. The Pharmacopeia of the United States of America, Eleventh Decennial Revision, 482.

(4) 1923. J. Biol. Chem. 58, 71.

1924. Ibid. 61, 405.

(5) 1928. Biochem. J. 22, 135.

(6) 1938. J. Am. Med. Assoc. 111, 528.

(7) 1937. J. Am. Med. Assoc. 108, 206.

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N. Y. State Jour. Med. 1935, 35-No. 11, 590 ☐

Laryngoscope, 1935, XLV, 149-154 ☐

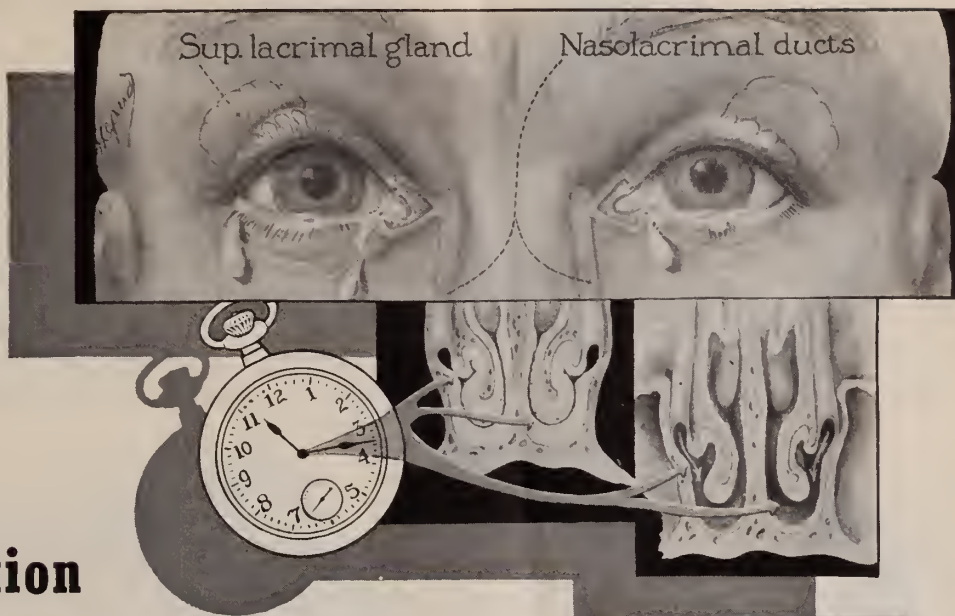
Laryngoscope, 1937, XLVII, 58-60 ☐

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Parkinson² states that "The purpose of local treatment during acute infection is ventilation in order to improve drainage. Shrinkage of the nasal mucosa opens the meatuses and the sinal ostiums."

As an aid to prevention of sinus infection, particularly in children, Osincup³ says: "Maintenance of a free flow of air through the nose and nasopharynx, complete drainage of the sinuses, particularly during infection of the upper respiratory tract, will prove of the utmost value."

Houser⁴ states: "The primary principle to be followed in all cases is to establish ventilation, and by so doing secure drainage of the infected sinuses."

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(laevo-alpha-hydroxy-beta-methyl-amino-3-hydroxy-ethylbenzene hydrochloride)

1. Proetz, Arthur: Am. J. Surg., Oct., 1938.
2. Parkinson, Sidney N.: J. A. M. A., Jan. 21, 1939.
3. Osincup, G. S.: South. M. J., June, 1933.
4. Houser, Karl Musser: Pennsylvania M. J., May, 1938.



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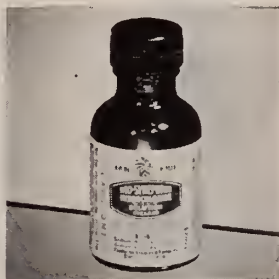
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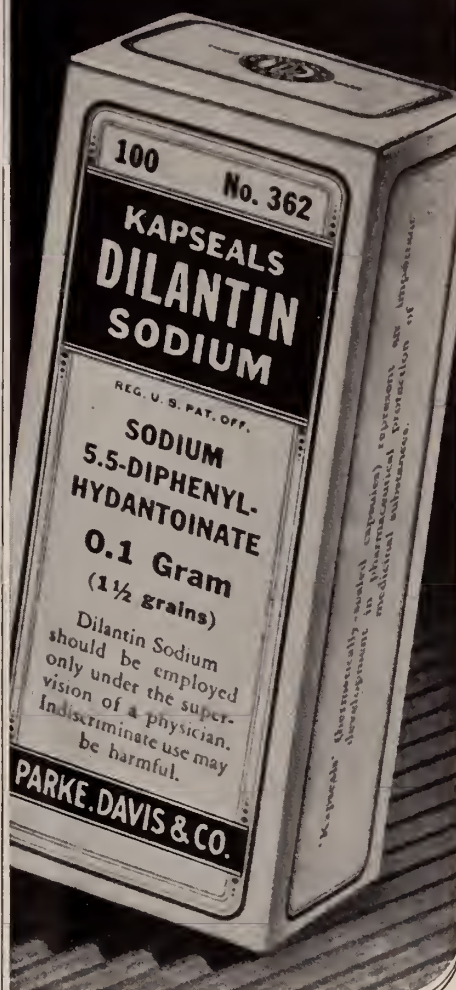
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PUBLISHED MONTHLY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



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EDITORIAL

The Fall Clinical Conference

The tentative program of the second Fall Clinical Conference of The Medical Society of New Jersey, which is printed on page 616 of this Journal, will appeal to every member. The Hudson County Medical Society will be the host, and the staffs of fifteen hospitals of the county will provide the material and discussions in all phases of medical practice. Every practitioner in the State will find something in which he has a deep, personal interest. But, besides that, he will find the demonstration of the facilities of the hospitals for diagnosis and treatment will be an inspiration and incentive to improve his own methods of practice.

The dominant subject of the Annual Meeting of The Medical Society of New Jersey is the practice of Administrative Medicine, as it has been during the 173 years of the existence of the Society. The leaders of the State Society have always been outstanding practitioners of clinical medicine, but it is impossible that they should bring their clinical cases or their scientific apparatus to the hotel in which

one thousand members meet. Only in the hospitals themselves can the wealth of clinical material be assembled and demonstrated to the visiting physicians.

The number of members who came from all parts of New Jersey to attend the first conference in Newark on October 6 and 7, 1938, exceeded the members that came to the Annual Meeting in June. There is every reason to expect a still greater attendance at the coming meeting in Hudson County.

The social feature of the coming clinical conference will be the dinner at the Carteret Club on the evening of the second day of the meeting. There physicians in private practice will greet their colleagues and will exemplify the unity of purpose for which the members of The Medical Society of New Jersey are noted throughout the entire country. To crown the evening there will be the inspiring address by Dr. Morris Fishbein, whose wealth of information is available to every member in the weekly issues of the Journal of the American Medical Association.

**Come to the Second Clinical Conference on November ninth and tenth,
and share in the distribution of the dividends accruing from
the year's operation of your State Society.**

The Physician and the Hospital in Relation to Child Adoptions

When America was young and predominantly agricultural, and its cities were small, the problem of securing good homes for dependent children was simple; and the physician, who "knew everyone", their standing in the community, and the heritage of the child, was frequently the placing agent, to the advantage of all concerned.

Today, with the tremendous increase in our urbanization so that we no longer know our own neighbors; with the astonishing mobility of Americans "on wheels", drifting about as may suit convenience or concealment; and with the alarming decrease in birth rate among certain classes, we are faced with an entirely new situation. There is on the one hand an urgent demand made by childless couples for children to adopt,—and the physician is one who feels that pressure first; and on the other hand, there are fewer normal, healthy children with good physical and mental heritage available for adoption.

So great is the demand for adoptions that out of it has grown a "racket in babies". The desperate state of the unmarried mother, the helplessness of the new-born infant, and the eagerness of the childless family, all have been commercialized by unscrupulous individuals and institutions. In one way or another the baby is "sold over the counter" with no adequate protection for the infant, or his mother, or the adopting parents, and no assurance that the child is normal and conformable to its new family relationships. It is for the protection of these three parties, and also of the physician, the hospital, and for society as a whole, that State governments are strengthening adoption laws. New Jersey's amended Adoption Act became operative on January 1, 1939.

A series of concise articles is now being prepared for publication in this Journal, in order to inform the physicians of New Jersey about the essential services which they can render in child adoption.

The Medical Service Plan of New Jersey

At the Annual Meeting of The Medical Society of New Jersey, on June 6-8, 1939, the physicians of the State, through their House of Delegates, gave their vote of approval to a Plan for the distribution of medical care among a selected low-wage group of the citizens of New Jersey. They instructed the officers of this Society to proceed with the formation of a corporation, to be controlled by the medical profession, for the purpose of administering this Plan.

Following these instructions, the Medical Service Plan of New Jersey was incorporated under the laws of this State on July 13, 1939. The incorporators are five members of this Society, designated by the Board of Trustees of the Society. The corporation has adopted a Constitution and By-Laws.

The Plan and the By-Laws have been presented to the Commissioner of Banking and Insurance for his criticism and suggestions.

These accomplishments since the Annual Meeting, although purely preliminary to the actual establishment and operation of the Plan, have required painstaking efforts on the part of the Board of Governors. These efforts are necessary in order that the Plan shall contain adequate safeguards to its subscribers and participating physicians, shall preserve intact the present patient-physician relationships, and shall make no attempt, either directly or by intimation, to dictate to any physician what his method of treatment or relation to his patient shall be.

In order to assist the Board of Governors in determining the proper procedures for the safe advancement of the Plan, and to prevent unnecessary pitfalls and complications, the Plans of other States have been studied carefully, and the progress of their development has been followed closely. Dr. Scott of the Executive Offices, who is acting as Secretary

to the corporation, has been in constant touch with the officers of the New Jersey departments who will be concerned in the operation of the Plan. During the summer months he made one trip to Maine to consult with an actuarial authority; spent two days at the annual meeting of the Michigan State Medical Society, which was devoted to the presentation and discussion of its Plan; consulted with officials of the A. M. A. in Chicago; and visited the Committee of the Toledo Plan.

The indulgence of the medical profession of New Jersey is necessary in order to allow the

Board of Governors sufficient time to perfect the many administrative details of the Plan. Their problem is a difficult one,—to plan for the medical care of this group of people, and at the same time to determine a means for paying physicians for rendering their services without in any way interfering with present methods of practice, or dictating or limiting the activities of any physician.

To this objective the Governors of the new corporation have pledged themselves, with every hope and expectation that in due time it will be accomplished.

Public Health Activities in Private Practice

The public health activities of a doctor in private practice may be defined as the delivery of professional and allied services in addition to the diagnosis and treatment of the specific complaints of his individual patients. The average physician engages in these activities to a greater extent than he is aware.

One of the younger physicians who is active in the private practice of pediatrics in a suburban county was invited to make a list of the public health features of his practice. He at once recalled three or four; but after a few days' consideration he produced the following list:

1. Eight years of private practice in pediatrics exclusively.

2. Three months' internship in contagious diseases under Dr. Richardson in the City Hospital, Providence, R. I.

3. Consultant during the summer of 1931 for the State Department of Health during the poliomyelitis epidemic, making spinal punctures and giving serum intraspinally in the homes of suspected cases in coöperation with the family doctors.

4. Eight years of service in the pediatric dispensary of a medical school.

5. Eight years of service in caring for children boarding in a county branch of the city Foster Home Service.

6. Three years' service in a syphilis clinic conducted by his county health department.

7. Five years of service in an infant and

preschool clinic of the county department of health.

8. For three years chairman of the diphtheria committee of his county medical society.

9. For five years chairman of the Milk Commission of his county medical society.

10. Consultation service for the county department of public welfare in cases involving unusual child guidance problems and glandular disorders.

11. Assistant attending pediatrician on the contagious disease service of the county hospital.

12. Giving occasional lectures to local Parent-Teachers Associations on contagious diseases, including syphilis.

13. Giving a lecture on "The Endocrine Glands" annually to an adult study group which is taking a course on psychology.

14. Holding a seminar on vocational guidance with older pupils and parents on "Choosing Medicine as a Profession".

In all these activities the doctor conformed to the standards of the county medical society. Some of these activities are official, for which he is paid a nominal sum, but with the approval of the county society.

This list of activities is not at all unusual; they are enumerated as examples of public health services in which many doctors in private practice are engaged to the satisfaction of the public as well as themselves.

Our Advertisers

Our advertisers are our partners in the project of The Journal. Oh yes, we *could* get along without the help of our advertisers, but we are grateful to them for paying the costs of the mechanical production and distribution of our monthly periodicals; and then too, our members appreciate the information and educational value of the advertisements to themselves personally. For one thing, our acceptance of an advertisement amounts to an endorsement of the product or service of the advertiser, especially of his character and reliability. Also, the advertisements constitute an index of the sources from which products or services may be obtained.

One of the most pleasing and satisfactory evidences of the mutual appreciation of advertisers and users of their products is that afforded by the commercial exhibits at the annual meeting. There, sincere appreciation and good fellowship prevail between the representatives and the doctors, just as it does between the physician and his patient.

An advertisement in The Journal is like the doctor's sign over the door of his office. Only a small proportion of those who pass by the sign ring his door-bell; but if his sign is not in plain sight, he may as well close up. Only a few doctors read the advertising pages of our Journal from end to end, but some really do, and more actually complain when they cannot find the advertisement giving the address of the dispenser of a product which they must have in a hurry.

About one-half of our advertisements come to us from the Coöperative Medical Advertising Bureau of the American Medical Association, whose sole function is to place the

announcements of the leading manufacturers of medical products which have a nation-wide distribution. A favorite device for testing the effect of the advertisements in the State Medical Journals is the use which physicians make of coupons offering samples or literature. One publisher of an expensive encyclopedia refused to renew his advertisement in the journal of one of the large medical societies because he had not received a single request for sample pages which he had offered. He said in a half joking way, "If I receive four coupons from an announcement in the forthcoming issue of your journal, I will immediately renew the advertisement." It happened that he received twelve requests, and he gladly kept his word.

Every doctor sees these coupons and other offers in our Journal, and many physicians are inclined to respond to them, but neglect to do so. If you are really interested in the offer, as many of you are, make use of it at once. This is especially important during the coming Fall months when decisions for renewing the advertisements are made, based on the tangible evidence that the advertisements are actually read and appreciated.

It is a gratifying fact that several large advertisers are seriously contemplating placing trial advertisements in the State Journals. Although you may not recognize your prospective customers, send for the coupons and literature that are offered in The Journal, and thereby demonstrate your interest in The Journal as well as the products which you will receive.

Finally, remember this fact: If it were not for the contributions of our advertisers, your annual dues would be increased by about three dollars.

Historical Articles

A series of historical articles is planned, to appear in each issue of The Journal, similar to the one on medical degrees on page 610. The Editor's spare time has been devoted to making an index of the early records of the Society in which the germs of most modern

activities are contained in isolated lines and brief paragraphs here and there. An index will render it easy to trace these developments. The articles will be records of what was actually thought and done by the early leaders of the State Medical Society.

ORIGINAL ARTICLES

THE SELECTION OF CASES OF PEPTIC ULCER FOR SURGERY

By HILTON S. READ, M.D., F.A.C.P., Atlantic City, N. J.

Read before the Combined Section on Gastro-Enterology and Surgery at the Annual Meeting of The Medical Society of New Jersey, June 6, 1939.

Within the short space of the author's memory the mere announcement of the title of this presentation would provoke any medical meeting into two hostile camps. Prejudices would be rearranged, and attempts made to impose them on the opponents. Much heat but little light resulted on the treatment of ulcer.

The familiar summary of Sir Berkley Moynihan's Harveian Lecture delivered March 22, 1923, may well remind one of the controversy that raged over whether peptic ulcer was a medical or surgical problem. I quote:

The separation between them (the physicians and surgeons), unhappily very wide and perhaps unfriendly, is to the grave disadvantage of medicine. In the treatment of these and other conditions a good understanding between them is essential to the welfare of the patient. If the physician judges of surgery after contemplation only of its failures, he should be persuaded to remember that the successes of surgery are won from the failures of medicine; and that the failures of surgery, serious as they are admitted to be, are a very trivial proportion in the volume of the rescue work. If the surgeon is prone to criticize the ineffective control of these diseases exercised by the physician, he may remember that these diseases affect patients, and that patients do not readily submit to discipline when a complete subsidence of their symptoms has been quickly produced by a treatment which the physician desires to continue for weeks or months beyond this stage.

I think it is a reproach to medicine that the surgeon should be compelled to operate so frequently for gastric and duodenal diseases. Such ulcers ought surely to be cured, far more often than they are, by medical treatment. Physicians who acquaint themselves with the pathology of a living gastric or duodenal ulcer realize how protracted and how scrupulous the medical treatment of so grave a lesion must necessarily be. If the practice of a few physicians became the custom for all, then perhaps we might find a way of escape from the grave disadvantages which result from the so frequent divorce of mind from hand in medicine.

Chamberlain finds he loves the Reds.* Franklin D. Roosevelt and business have decided to bury the hatchet (not in the consumer, we hope). The physician-surgeon peptic ulcer battle, which was doing the art and science of medicine and the patient no good, has resolved itself into a tolerant philosophical approach to a most trying disease. As eloquent testimony to this satisfactory state we have the surgeon President of the American Medical Association telling the American College of Physicians: "It is now the consensus of opinion that the problem of the treatment of peptic ulcer is primarily a medical one, assuming surgical significance only with its complications, sequelae, and intractable chronicity"; and the President of the American College of Physicians opinionioning to the Clinical Congress of the American College of Surgeons, with the nodding assent of his listeners, that patients with peptic ulcer must be treated medically from the time of the diagnosis to the end of life, with employment of surgery for the complications and the retaining of the physician even when the surgeon is called.

An internist from an overgrown fishing village must perforce approach a discussion of the subject with humility. Over a thousand communications on some phase of peptic ulcer find their way into the literature each year, and it is not our lot to add any professorial profundity to the subject. We meekly act the rôle of an inquiring reporter, running a sort of Gallop poll on the assigned title. We have attempted to brief the recorded opinions of surgeons, mainly, from coast to coast, and from Canada to the Gulf. One cannot help

The year 1939 had three epochal rapproche-

* It is interesting contemporary history that at the time of the presentation of this paper an English military mission was in Moscow.

but be impressed by the fact that A. J. Present, in a paper, "Peptic Ulcer", in the *Annals of Surgery* for July, 1938, found 150 references of sufficient interest and import to list in his bibliography. There are a very few who will resent any discussion of gastric and duodenal ulcers under the title of peptic ulcers. They will perhaps forgive our transgression, and consider as justification the fact that both the stomach and duodenum arise from the foregut, that both receive their blood supply from the celiac axis, that each is bathed by gastric secretion, and that the vascularity of each is similar in that it is of the endartery type with a paucity of capillaries.

Hungry Samuel Johnson of dictionary fame once ground out a book on Ireland as a means of securing a few meals. His encyclopedic type of mind required him to head a chapter "Snakes in Ireland" which was followed by the statement, "There are no snakes in Ireland." A strict interpretation of the title of this presentation would require the statement, "There is no surgical treatment of peptic ulcers." Not being inclined to be too literal and taking what we believe to be the intent of the title as a license, the essay may be continued with the statement that surgery is to be reserved for the *complications* of peptic ulcer. Its employment for these is not a matter of "one plus one equals two" logic, but rather requires a nicety of judgment unequalled in other medical dilemmas.

It may be acceptable to many to state that in the direct order of urgency, and in an inverse order of frequency, these complications are perforation (8%); hemorrhage (12%); obstruction (26%); and intractability (pain—54%). The figures are from the indications for 100 consecutive operations by Crile.

The absolute indication for urgent and early surgery is *perforation*. No medical mind from the third year of medical college onward will dismiss the board-like rigidity and shock of the acutely perforated peptic ulcer with other than surgery.

It must be recalled that perforation is often the first announcement to patient or physician of the presence of an ulcer. Mindful of the four per cent hourly increase in mortality,

early diagnosis and the institution of the appropriate surgical treatment are the essence of success. More mature consideration and reasoned caution is necessary to interpret properly the change from *periodicity* of pain to *constant* gnawing as the change occurs from an ulcer warranting medical management to apperitoneal irritation demanding surgical intervention. Oftentimes the decision to employ surgery here, as elsewhere in the other elective peptic ulcer problems, hinges on the attitude of the clinician regarding the effectiveness of continued medical control, the degree of disability that the lesion provokes, and the surgical skill and facilities available.

Bleeding as an indication for the employment of surgery is still somewhat of a moot question. At least it does not enjoy the serenity of definiteness that perforation does. The treatment must carry the dual approbation of surgeon and internist. It has been variously estimated that 20 per cent to 35 per cent of ulcers bleed. Correct or incorrect, these figures cannot but impress one with the concern which this complication warrants,—concern of a greater degree in the treated patient than in the untreated patient who bleeds.

Two types of bleeding must be considered,—the slow ooze producing a secondary anemia, and the massive sudden loss of blood sometimes providing a mode of exit for the victim. According to one series of 1804 patients with duodenal ulcer, 613 had massive hemorrhages, among whom 14.5 per cent died because of the bleeding.

Another series of 890 patients with peptic ulcer produced 38 per cent with massive hemorrhages, and a mortality of 11 per cent due to exsanguination. These figures would seem to discredit the lore which still affects some medical minds that patients with ulcer never bleed to death, or at least like Gilbert and Sullivan's ditty, "Hardly ever" do. Certain it would appear is the significance of hemorrhage with its increasing danger of fatality in patients passing fifty years.

The acute massive hemorrhage of shock-producing proportions is not uniformly accepted as an indication for prompt surgery.

There may be a majority subscription to the statements that:

1. In the chronic ulcer with oozing, operation is a matter of election conditioned much the same as is intractability as an indication.

2. Operation is to be urged in the better risk patients in the older groups in the acute stage of bleeding without extending the delay past forty-eight hours.

3. Peptic ulcer associated with massive hemorrhage should be considered a surgical lesion as an elective procedure, regardless of the age of the patient, in those who have spontaneously recovered from an episode of bleeding.

Internists and surgeons alike will continue to absorb considerable mental torture in the management of the individual (particularly under fifty) who continues to bleed from a peptic ulcer despite all nonsurgical efforts to check it. Things often go from bad to worse while we are hoping for them to go from bad to better. Having passed up previous propitious moments, one must sometimes regretfully seize a desperate gamble prepared for any eventuality. At no time is a patient less able to stand any surgery (let alone the extensive surgery often demanded in this emergency), than after a sudden loss of blood. Just as no positive signal announces the time to terminate masterly inactivity and start surgery for hemorrhage, so the surgeon who is obliged to operate under these conditions should be spared censure—self-imposed or otherwise.

Interference with the physiological duties of the stomach, as is produced by cicatricial stenosis following peptic ulcer, has such a profound effect on the individual that few will wish to deny him the chance of surgical relief. However, one must not be seduced by the transitory obstruction of edema, or the acute exacerbation of an ulcer. Time does not have to be grabbed by the forelock in applying the remedial effects of surgery to this condition. Adequate opportunity is often available to establish whether or not it is real scar tissue that is impeding the normal performance of the stomach. We cannot help but be reminded at this point of the similarity of the problem here to the retort supreme of one of our for-

mer iconoclastic psychiatric chiefs at Blockley. It was his habit to squelch all therapeutic enthusiasts when they started to eulogize any particular "Cure" for paresis. "What happens", he would inquire, "when the spirochete invades the central nervous system?" "Why lymphocytic infiltration", the interne would reply. "And what follows that?" "The production of fibrous tissue." Then we were deflated by the Chief's caustic, "Can you think with that?" Belladonna, bromides, bromural, and any barrage of bunkem prescribed by detail men will not dissolve scar tissue about the pylorus or anywhere else. By the same token, inopportune surgery on an edematous gastric mucosa or spastic pylorus will probably result in no improvement, and may even have serious repercussions.

Finally we come to intractability as an indication. To this field we dedicate the conglomerate conscience of Medicine. Typewriter ribbons could be worn to shreds rambling about this indication without proving a thing. Here it is that the personal equation has full swing. "A man convinced against his will is of the same opinion still." This may account for the high percentage incidence of this indication for operation in certain series. The best service one could render in the discussion of this point would be to pray for the hypertrophy of the collective conscience of the consulting minds in the use of this indication. We might also wish an accompanying atrophy of the natural tendency to rationalize, to believe in the right of what we desire, which is too often wishful thinking.

You may believe or disbelieve in the origin of gastric cancer in previous ulcer sites. Certain it is that some reflection must be spent in considering the possibility of cancer as explaining the intractability of what was taken to be an ulcer. The statistics on inoperability are mute—yet perhaps eloquent—indictment of our unwillingness to consider, with Walters, all gastric ulcers as malignant until proved otherwise.

In the use of this indication for surgery everyone must set up his own standards of intractability, as to the number of medical cures the patient must experience or how many

symptomatic recurrences he should endure under medical treatment, in the absence of complications, before surgical consideration of the lesion may be entertained. Here particularly, but in all the indications, the pattern should be cut by a joint board of roentgenologist, gastroenterologist, surgeon, and internist, with the latter as coördinator, for it is, after all, the individual and not the ulcer that appeals for relief. Intractability is the least valid indication, the one that causes the consultants the most headaches, the least comforting to patient and medical adviser alike. Contributors to intractability like endocrinal influences, ptosis, ego frustration, the unfortunate choice of parents, vanishing bank balances, and carping wives and husbands have been known not to respond to surgery.

It is perfectly true that early surgery means easier surgery. If surgery is to be employed, it should be only so early as seasoned reason dictates, and not an escape reaction sired by panic out of despair to provide an "Out" for either physician or surgeon, a sort of "Try anything to get this patient off my neck" attitude. This is one condition in which there can be no dodging of responsibility—no conscious or unconscious dishonest conditioning of one's cerebral gymnastics to avoid community censure. Frank exchange of opinion, fortified by as many findings of the numerous auxiliary investigations as time and reason dictate, is the order of the day. This should be followed by a united front attack by physician and surgeon alike. Preparations for any eventuality is required. The fact is established that five per cent of the patients will die despite any and all treatment under the most favorable conditions of the best equipped and staffed medical center.

Much remains to be found out about the cause of ulcers and the mechanics of the production of pain, among other things. Consequently, any chosen treatment is on an unsound foundation. Two problems in treatment occur to one. They are the relief of symptoms, and the healing of the ulcer. One fact we may oft-times recall with profit is that medical management may be eminently satisfactory for relief with no effect at healing.

The two phenomena do not of necessity go hand in hand.

It is only fair to relate that at least one voice has been raised, not necessarily in support of surgical treatment of uncomplicated ulcers, but in an effort to remove any medical smugness about peptic ulcer therapy. Perhaps the point is well taken that sometimes the menace of complications is too great a risk to ask an individual to harbor. But can the individual with an ulcer be assured that he will not experience a recurrence, or perhaps a fatality? Or will the removal of the ulcer be any more successful in the treatment of its host than the treatment of a nephritic retinitis would be in curing the ailing kidney?

Our sole personal contribution in this communication is to appeal for more meticulous care in the management of the patient with an ulcer, whether he be under surgical or medical management. We seashore physicians frequently see individuals recently discharged from surgical hands with the indefinite post-operative instructions to go to Atlantic City and get a lot of rest, sunshine, and salt air, and the single admonition not to eat too much. The finest of medical minds and the deftest of surgical hands may come a cropper for failure to supervise and individualize the pattern of life for the individual with an ulcer past or present.

In his *Surgical Pathology* Boyd describes the stomach as "Weeping for its neighbors and often overdoing it as to obscure the basic sources of trouble". Many a strong man has been unwittingly hamstrung for life by a discretely dropped tear, and medical men (surgeons and internists alike) often rue the day they mistook the sympathy of the stomach for the wail of organic disease therein.

I cannot help but recall the admonition of my beloved hospital Chief, Dr. David Riesman, as he warned us that in the space of a few centimeters in an area hardly larger than a silver dollar are the outlets of the stomach, gall-bladder, and the pancreas. "The Balkans of the abdomen", he called this oft scalpel-scarred zone. Little wonder that he stated that one's positiveness in diagnosis was in inverse proportion to one's experience. When speak-

ing of such a whimsical valley as the right upper quadrant, an internist will perhaps be forgiven for suggesting great caution in diagnosis as preëminently the crux of the choice of cases of peptic ulcer for surgery.

Sir Berkley Moynihan opened his Hunterian Lecture on January 29, 1923, with the following paragraph. I quote:

A backward look over a few years in the course of a man's life may be of great value. It is very necessary for the surgeon, whose opinion and whose practice can rarely stay unchanged. For he is one who must always be in eager search of a sounder judgment, or better method; reluctant to abandon any well-proved conclusion or trusted procedure, he will yet remain quick to give the fullest consid-

eration to all the lessons that increasing experience may seem to teach.

To review our work is a very stern and salutary discipline. It will make clear the need to correct the impressions, often vague and sometimes very treacherous, which have been gained rather from the occasional dramatic occurrence than from the tranquil observance of a daily and placid routine; it may confirm our faith in convictions which have slowly grown and strengthened almost imperceptibly; it will lead us to test once again an opinion not quite too impregnable as we had thought. The correlation of many incidents, apparently unrelated, at the scattered times of their occurrences, will provoke a new inquiry, or reveal a truth which lay buried deep. From a long array of cases we can glean knowledge that the single case can never disclose. The years certainly teach much that the days never knew.

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MACROCYTIC ANEMIA

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Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey, June 8, 1939.

A macrocytic anemia is characterized by an increase in the size and volume of the red cell. When there is an increase in the haemoglobin concentration of the red cell, the anemia is designated as hyperchromic and macrocytic. Only macrocytic anemias may be hyperchromic, and the shorter term will be used in this paper.

The presence of a macrocytic anemia may be demonstrated in the peripheral blood of many unrelated diseases; hence that anemia may not be considered a disease entity, but rather as part of a syndrome in which there is a failure of maturation of the red cells.

The red cell normally undergoes all the stages of development within the confines of the bone marrow, emerging into the circulat-

ing blood as a fully developed adult red cell. The first stage of differentiation in the red cell formation is called the *megaloblast*. This cell divides to form the *erythroblast*; which in turn matures to form the *normoblast*, the last of the nucleated red cells. The normoblast loses its nucleus to form the *reticulocyte*, which eventually becomes a mature *erythrocyte*. Few megaloblasts are seen in the normal bone marrow.

The stimulus for the maturation of the red cell comes from a specific substance, called by Castle the *erythrocyte maturing factor*, or *liver factor*. This factor is believed to be formed by the union of a secretion of the stomach glands, called the *intrinsic factor*, with some element in the ingested food called the *extrin-*

sic factor. The extrinsic factor is found in large quantities in beef, autolyzed yeast, liver, and eggs. The erythrocyte maturing factor is fully developed in the small intestine, where the low acidity is favorable for its formation. The factor is absorbed through the portal vein, and passes into the liver where it is stored, and probably undergoes some further alteration. The liver discharges the erythrocyte-maturing factor into the blood stream as the need for this stimulus arises in the bone marrow.

DIAGNOSIS

The diagnosis of an hyperchromic macrocytic anemia is made in the laboratory. The size, volume, and haemoglobin concentration of the red cell are accurately determined from data obtained from the red cell count, volume of the red cells packed by centrifugation—that is, the haemocrit reading—and haemoglobin determination. The routine blood count should in most instances serve as sufficient data for the diagnosis of this specific type of anemia. When further substantiation is necessary, or where more accurate information for scientific study is required, the newer mathematical coefficients assume an important rôle in the classifications of anemias.

Briefly, the presence of a high color index, and macrocytosis in the peripheral blood make the diagnosis simple. But the determination of a macrocytosis, if conscientiously ascertained by measuring the individual red cells in microns, is a tedious one, demanding special apparatus and technical skill. Even with these the determination may be fraught with the possibility of error.

Ingenious haematologists of the past ten years have given a more scientific approach to the evaluation of an anemia, by taking the simple data obtained from the red cell count, volume of the red cells packed by centrifugation, and haemoglobin determination. Probably the most important computation was the mean corpuscular volume. This is the average red cell volume expressed in cubic microns. The average mean corpuscular volume is eighty-five cubic microns. In the presence of a macrocy-

tosis, the mean corpuscular volume will usually rise above 100 cubic microns.

Another computation arrived at was the mean corpuscular haemoglobin, which expresses in micromicrograms the average haemoglobin content of a single red cell. Normally the haemoglobin content of the average red cell is thirty micromicrograms. In macrocytic states the average corpuscular haemoglobin rises to thirty-five or more micromicrograms. With the information obtained from the red cell count, haemoglobin, mean corpuscular volume, and mean corpuscular haemoglobin a diagnosis of a macrocytic anemia can be made accurately and easily.

PERNICIOUS ANEMIA

Pernicious anemia constitutes the majority of cases of this type of anemia. This disease is dependent upon the inability of the individual to produce the erythrocyte-maturing factor, because of a diminution, or lack in, the secretion of the intrinsic factor. Pernicious anemia is characterized by a progressive hyperchromic macrocytic anemia, leucopenia, complete achlorhydria, even after the injection of histamine, and rather typical gastro-intestinal and neural manifestations. When the red cell count falls below 2,000,000, the typical bone marrow picture of a megaloblastosis appears. The disease is principally one of middle life; occurs more frequently in females, and is seen very rarely in the Negro race.

The typical case of pernicious anemia is brought to the physician because of the symptoms referable to anemia: pallor, weakness, and dyspnoea. As the anemia progresses, a lemon tint to the skin, and icterus of the sclerae develop. Gastro-intestinal symptoms are commonly encountered. Glossitis, characterized by a smooth, sore tongue, is a classical finding. Nausea, epigastric pain, vomiting, and diarrhea are frequently present. Numbness and tingling of the hands are seen very often in early cases long before any evidence of anatomic neural involvement.

About 40 per cent of the cases develop distinct changes in the spinal cord, with varying degrees of subacute combined sclerosis, and with clinical manifestations ranging from loss

of vibratory sense and weakness of the lower extremities, to frank paralysis, and loss of bowel and bladder control. In extreme cases secondary thrombocytopenia with purpuric manifestations may complicate the blood picture.

Untreated cases of pernicious anemia are usually fatal in from two to three years. Spontaneous remissions occur in a very small percentage of cases, without treatment, and with return of the blood picture to one indistinguishable from normal; they may last from several months to several years before a return of clinical and haematological symptoms indicating a relapse.

With the advent of liver therapy in pernicious anemia, a drastic change occurred in the course and prognosis of the disease. The patient suffering from pernicious anemia may, with adequate therapy, enjoy a normal existence, free of any clinical or haematological symptoms of the disease.

Adequate therapy consists in the patient receiving sufficient oral or intramuscular liver extract, or dessicated hog's stomach, which will induce a maximum reticulocyte response in seven to eight days, and a return of the blood picture to normal. The patient should become clinically symptomless, or should show an arrest in the gastro-intestinal or neural damage.

The potency of any material used in the treatment of pernicious anemia is expressed in *reticulocyte units*, and is gaged by its haematological response. The reticulocyte unit is that amount which, when given daily to patients with pernicious anemia, will induce a satisfactory haematopoietic response. No longer are preparations gaged by the amount of material used. The dosage recommended is not less than one reticulocyte unit daily, whether given at varying intervals, usually not longer than one week, although some cases may do well on monthly injections. The greater the initial anemia, the greater the reticulocyte response, the probable maximum response being determined in advance by mathematical computation. The physician may thus check the efficiency of any preparation being used.

One must bear in mind that the amount of material constituting a reticulocyte unit is de-

termined principally by its haematopoietic response, and may not be sufficient to alleviate the gastro-intestinal or neural symptoms. Haematological recovery does not imply neural recovery. Some authorities feel that maintaining a case of pernicious anemia with a blood count under 4,000,000 red cells per cm. may be inductive to neural damage. The neural or cord unit is not identical with the reticulocyte unit. Authorities who believe that crowding too many reticulocyte units into one cc. of material reduces or destroys the cord factor, recommend preparations having no more than five reticulocyte units per cc.

SPRUE

Pernicious anemia may be closely imitated haematologically and clinically by anemias arising from alimentary disease, and every care must be taken to exclude the latter before a diagnosis is made.

Sprue simulates more closely pernicious anemia than any other disease. Sprue may have a peripheral blood picture and bone marrow findings identical with that of pernicious anemia. The disease, divided into a tropical and non-tropical form for geographic reasons only, is characterized by wasting, diarrhea, glossitis, stomatitis, and an anemia more often macrocytic. In this disease free HCl can be demonstrated in 90 per cent of the cases after the injection of *histamine*. The sugar tolerance curve shows little or no absorption of the glucose; whereas in pernicious anemia the curve is normal or may resemble diabetes mellitus. Because of a defect in the absorption of the erythrocyte-maturing factor from the intestinal tract, the bone marrow does not receive that stimulus for maturation of its red cells.

Steatorrhea (excess of fat in the stools) is commonly seen in sprue; and after long bouts of diarrhea tetany it may occur from calcium depletion. Even without treatment the death rate is not high. Neurological symptoms are not common even in cases with severe anemias of long standing. These cases do as well on liver extract as do pernicious anemia patients. The point must be stressed that oral treatment will not be very satisfactory because of poor absorption from the intestinal tract. Those

cases of sprue with a microcytic anemia do not respond to liver extract.

Carcinoma of the stomach may occasionally simulate pernicious anemia, especially if there is an achlorhydria, and absence of x-ray confirmation. These cases apparently do well on liver therapy for some time; but with extension of the malignant process, the typical features of the disease appear, namely—cachexia, occult blood in the stools, persistent epigastric pain or discomfort, and finally x-ray evidence, and the patient begins to go rapidly downhill to a fatal termination despite liver therapy.

A macrocytic anemia may occur during the course of a pregnancy. Such cases may be due to a relatively low intake of the extrinsic factor to meet the demands of the mother and the fetus. These cases do well with liver therapy, and there is a spontaneous cure after the delivery of the fetus. One must bear in mind that cases of pernicious anemia may become pregnant, and must receive the same care as usual.

Diffuse liver disease interfering with the proper storage of the erythrocyte-maturing factor may give rise to a macrocytic anemia. The extensiveness is not parallel by the degree of macrocytosis, and very often severe damage is unaccompanied by macrocytosis. The explanation for the latter may be that other organs, probably the kidney, may store the erythrocyte-maturing factor.

There is an *achrestic anemia*, characterized by a severe hyperchromic macrocytosis, having free HCl, and reacting poorly or not at all to liver therapy. This anemia was at first thought to be a type of pernicious anemia that was not amenable to liver therapy; but the

opinion held now is that the disease is probably a manifestation of aplastic anemia. The disease is thought to result from a failure of the bone marrow to utilize the erythrocyte-maturing factor. The marrow in these cases may resemble that of pernicious anemia. The presence of free HCl, low mean corpuscular volume of the red cells; and failure to react to liver, should serve as differential points. No gastro-intestinal or neural symptoms are present in achrestic anemia.

Nutritional disturbances due to a deficient intake in the extrinsic factor may result in a macrocytic anemia. In some cases of pellagra a macrocytosis occurs. The presence of a dermatitis, mental deterioration, and a history of dietary deficiency serve to differentiate it from pernicious anemia.

In cases where the intestinal contents are shunted off, as in gastro-colic fistulae, jejuno-colostomy, or diseases in which the absorbability from the small intestine is disturbed, or where total gastrectomy has been performed, macrocytosis may occasionally occur. Any disease in which the gastric or intestinal contents are lost by persistent diarrhea or vomiting loss of some element of the factor or loss of the factor, may technically give rise to a macrocytosis. These cases are not common.

On extremely rare occasions a macrocytosis may be seen in fish tapeworm disease, myeloma, or leukemia.

In conclusion, macrocytic anemia appears with some disturbance in the synthesis or utilization of the erythrocyte-maturing factor. The differentiation of the various diseases of the macrocytic group is usually completed in the laboratory. Failures in the treatment of so-called pernicious anemia may be due to faulty diagnosis.

CARDIAC PAIN

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Rarely a day passes that the doctor practicing medicine does not have a patient who gives the symptoms of pain in, or over, the heart. This paper is written with the hope that the correct differentiation can be made between the kinds of pain arising from three sources:

1. That which is due to organic disease of the heart, such as angina, and coronary thrombosis.

2. That of a cardiac neurosis, such as neuro-circulatory-asthenia.

3. Some of the numerous extrinsic conditions whose subjective symptoms are referred to the heart by the patient.

HISTORY

First of all a most careful and full history must be taken. The following conditions are inquired into in connection with the past history—rheumatic fever, growing pains, chorea, scarlet fever, tonsillitis, diphtheria, and history of puerperium. Other diseases or surgical operations are also noted.

The following symptoms are considered important: Pain, dyspnea, cyanosis, orthopnea, constriction, palpitation, exhaustion, coughing, and giddiness.

With regards to pain, the points especially asked about are its position, radiation, and duration; and its relation to exhaustion and emotion.

Inquiry is also made as to whether the pain occurred during exercise, and if it is made worse during exercise or if it is worse when exercise is finished; also whether it occurred when the patient is resting, or is in bed. The patient is asked if he is able to play games, and to walk without pain or dyspnea with specific reference to climbing stairs and to running. His habits as regards smoking, alcohol, tea and coffee are also investigated.

On physical examination the following should be noted:

The presence of dyspnea, orthopnea, cyanosis, pallor, pulsations, clubbing of fingers, and

tremor, the pulse rate, both standing and lying; and the state of peripheral arteries and veins.

The heart is examined by inspection, palpation of the apex beat, palpation of the precordium for abnormal impulses or tremors, the position of apex beat, the area of cardiac dullness, and the quality of muscle sounds.

Pre-cordial hyperesthesia is tested for in every case, and the lungs and the abdomen are examined. Electrocardiograms should be taken in all cases. Wassermann test is done, and a six-foot film of the heart and its contour are taken.

The pain in the heart not due to organic disease is usually definitely neurotic. Here a clear diagnosis is essential, for if a diagnosis of angina pectoris is made incorrectly, we have made an invalid of a healthy person. On the other hand, if we fail to make a proper diagnosis, we have undoubtedly hastened the death of the patient.

It is best not to commit ourselves on the first or second examinations, but to observe him and use all tests at our disposal.

Another point is that neurotic pain may occur at the same time with organic heart disease; and it is known that frequency of neurosis is higher among those who suffer from organic disease. The term *functional heart disease* does not sufficiently cover the field, and the present one—neuro-circulatory-asthenia—is more descriptive and sufficient. This last term is the outgrowth of those war terms: soldier's heart, disordered action of the heart, and effort syndrome. This we saw in great numbers in the war, brought on by infectious diseases, over-exertion, bad news from home, etc.

The symptoms of neuro-circulatory-asthenia were legion, including cyanosis of the hands and feet, easy fatigueability, sleeplessness, stabbing pains and signs of soreness around the heart, palpitation, dyspnea, and a complaint of breathlessness which consists of sighing or inability to get enough air in the lungs. Physi-

cal examination in these cases reveals generally a normal-sized heart, but often pre-cordial hyperesthesia, the patients often wincing when pressure is made over the pre-cordium. The heart sounds are normal and generally no murmurs are present. In other words, a normal functioning heart is present. The lungs and abdomen are normal. The blood pressure, while normal, often falls as much as 20 mm. when the person assumes the erect posture after lying down for five minutes. Most cases show normal E. K. G. and radiographic examinations.

As to differential diagnosis: pain left-sided in nearly every case, and lassitude is more a marked symptom and more severe than the milder lassitude of the angina of effort. Palpitation is more pronounced here and very mild in angina pectoris. A most pronounced symptom is marked change of color of the hands, if they are held out in front and questions are fired at the patient. They change from pink, to blue, and to purple. There is also cold moisture in the palms of the hands.

The most logical cause of this pain and train of symptoms is an over-activity of the central nervous system, due to psychological or endocrine factors, or occasional foci of infection.

PROGNOSIS

As to prognosis, nearly all of these cases will recover, but the recovery is prolonged to one or more years, and relapses can be frequent. Before dismissing this condition, it must be remembered that neuro-circulatory-asthenia can also exist with organic heart disease, mitral stenosis being most guilty lesion. In this condition, rest, reassurance as to their recovery, gradually increasing graded exercise and nerve sedatives are best. Digitalis is not indicated here, and nitroglycerin is of no avail.

FATIGUE PAIN

Next to be mentioned is simple fatigue pain. Muscle fatigue can cause a majority of cardiac pains, since any muscles when exhausted are painful. This can be caused by numerous things as in the hypertrophied hearts of aortic stenosis, mitral stenosis, or congenital pulmonic stenosis. The pain is a dull one in the region of the apex or lower precordium.

Fatigue pain may come in arterio-sclerotic heart disease when the coronary arteries are so narrowed that the myocardium is not nourished enough with blood, a sign of fatigue of one or both ventricles. This is not the same of true angina pectoris.

Fatigue pain may also result from the extra effort caused by paroxysmal tachycardia, or auricular fibrillation, or flutter; or by permanent auricular fibrillation or flutter, when these two are not controlled by digitalis or quinidine. Congestive heart failure also causes this pain, as is evidenced by its disappearance with treatment by rest and digitalis. It must be remembered that, with different degrees of sensitiveness to pain, some patients will complain much more than others, the same conditions being present in each.

In this condition, I have tried to impress the fact that it is very common to have cardiac pain or distress, which has no relation to angina pectoris or coronary occlusion; and while it is usually neurotic in character, it is treatable in nearly all the cases. Again it is of great importance to differentiate, for the patient's welfare to prevent anxiety—neurosis, or semi-invalidism, between the above symptoms of minor importance and the interpretation of symptoms of serious organic diseases, which will next be taken up. In discussing the symptoms of cardiac pain, due to organic conditions, I am taking the classifications of Wood and White.

PAROXYSMAL HEART PAIN

Wood and White think that in paroxysmal heart pain (the so-called true angina pectoris), it is likely that coronary irritability causes paroxysmal heart pain by giving rise to coronary spasm, and thus an acute anemia and acute exhaustion of the myocardium. They think that there need be no extensive arterio-sclerosis, nor possibly any microscopic pathological condition at all; and also that conditions may be an early sign of coronary disease, there being for many years vessels just diseased or irritable enough to produce the paroxysmal pain.

Pre-disposing causes of paroxysmal pain:

A. Congenital.

1. It often runs in families, and sudden death often occurs in persons after the age of forty-five, because of an inherited impaired cardiac-vascular system. It is now well known that it can also occur in young people in their thirties.

2. It is likely to occur frequently in the intellectual and cultural society.

3. Unstable, psychic and emotional background, even an accident witnessed, attending an exciting movie, or game of cards.

4. Wear and tear of modern life, with the hard work struggling for a livelihood to which people have been accustomed. Worry is one of the greatest causes.

5. Exposure to extreme cold.

6. Age—it is a disease of middle life.

B. Acquired causes—much less common than the above.

1. Infection,—sometimes influenza or pneumonia.

2. Toxic symptoms from tobacco excess, by producing vasoconstriction of peripheral arteries.

3. Hyperglycaemia, due to excessive doses of insulin.

4. Sometimes by mechanically preventing enough blood getting to the coronaries. This condition can occur in mitral stenosis—less blood going to left ventricle from left auricle, and also with a low diastolic pressure in aortic regurgitation.

Attacks of angina appearing after effort may be caused by:

1. Physical,—as an excess of muscle activity and fatigue.

2. Mental excitement or emotional upset.

3. Vaso-motor,—exposure to cold or walking against a chilly wind.

4. Gastro-intestinal,—over-eating, even at rest after every meal.

5. Occasional sexual excitement, including physical effort, psychic effort and endocrine activities.

There are two modes of onset of this pain:

1. The "explosive type" in which pain appears suddenly, rapidly reaches the crest, and disappears abruptly.

2. The "gradual onset type" where there may be some prodromal symptoms. The pain

comes on slowly, taking several minutes for the acme to be reached; and then gradually disappears. The attack is ushered in by a sense of band-like constriction behind the sternum. This becomes progressively worse, and with it the pain seems to be squeezed upwards and downwards into various parts of the chest, then often spreading to neck, arms or epigastrium.

Some of the more common prodromal symptoms are tingling and numbness of fingers, wrists, and arms, and peculiar sensations in the neck, throat or face, or are referred to the gastro-intestinal tract. When the pain arrives, it can be stopped or aborted by a nitro-glycerin tablet placed under the tongue.

The pain in angina varies greatly in type, severity, and location. It is mostly a sense of constriction or squeezing, as if the heart was held in a vise. Most pain will be described as boring, drilling, burning, or stabbing, or shooting. The radiation of pain has been described, and after its cessation there will be left pain-points or areas of hyperaesthesia, most common on the front of the chest, especially the anterior axillary line.

The three most common complications of angina pectoris are:

1. Coronary thrombosis,—which often follows repeated attacks of angina.

2. Hypertension,—which sometimes occurs later.

3. Congestive heart failure,—this being the chief cause of death in all angina pectoris cases, unless the sudden accident of coronary thrombosis intervenes. When congestive heart failure occurs, the angina syndrome disappears.

Other less frequent complaints are:

4. Coronary asthma, due to heart failure.

5. Pulsus alternans.

6. Rarely heart block.

7. Rarely auricular fibrillation.

8. Arteriosclerosis,—generalized or localized.

9. Diabetes,—questionable and unusual.

THE PAIN OF CORONARY THROMBOSIS

This may last for hours or days; and is so severe that shock is always associated with it, with collapse, ashen color of the skin, irregu-

lar and weak heart action, and cold, clammy skin. In contradiction to the pain of angina pectoris here, it may come on, with or without, preceding exertion. It is most common in individuals over forty years of age, who have had a hypertension. The radiation is similar to that of angina pectoris, but more often is referred to the epigastrium. Nitrites never relieve the pain; and occasionally even large doses of morphine do not control it. The blood pressure always drops, and leukocytosis with fever always follows within a day or so, as it is an inflammatory reaction. With the infarction causing pain to be referred to the epigastrium, the differential diagnosis of acute appendicitis, ruptured gastric, or duodenal ulcers, acute pancreatis, must be made.

I have seen at least three cases prepared for operation which were acute coronary thrombosis.

I would like to give a few differences between angina pectoris and coronary thrombosis:

ANGINA PECTORIS

1. Pain—Sudden onset of angina pain, after exertion (angina of effort), excitement, over-eating, or cold, fright, or anger.

a. Location,—Substernal.

b. Radiation,—To neck and down the left arm, only in typical cases.

c. Duration,—Intense pain, which lasts only a few seconds or a few minutes.

d. Response to nitroglycerin,—Place tablet under tongue.

e. Occasional prodromes.

2. Shock symptoms,—Rare and light.

a. Face,—Pale and fixation of features—prominent eye-balls.

b. Pulse,—Characteristic, slight increase in rate. No irregularity.

c. Blood pressure,—Not much change; it may be slightly increased.

d. Respiration,—Slow and measured breathing. No dyspnea.

3. Behavior of patient—Quiet. Silence and immobility. Fixation on the spot.

4. Temperature,—Normal.

5. Sedimentation rate,—Not increased.

CORONARY OCCLUSION

1. Pain—Sudden onset of anginoid pain no relation to effort.

a. Location,—Substernal or epigastrium..

b. Radiation,—Not common.

c. Duration,—Very intense pain, lasting for hours or days. Sometimes responds to large doses of morphine by hypo, frequently repeated. No response to nitroglycerin. No prodromal warnings.

2. Shock symptoms—Severe and profound shock is the first symptom.

a. Face,—Pale, ashen gray, anxious. Skin is cold and clammy.

b. Pulse,—Rapid, feeble and thready—sometimes hardly perceptible.

c. Blood pressure,—Marked reduction—both systolic and diastolic. Blood pressure falls almost immediately and stays low for some time.

d. Respiration,—Dyspnea on the slightest exertion.

3. Behavior of patient—Usually very restless. Quite frequently vomiting.

4. Temperature—Subnormal during attacks. Fever 24-72 hours later with leukocytosis.

5. Sedimentation Rate—Increased.

PAIN IN PERICARDIAL AND HEPATIC ENGORGEMENT

These are quite readily recognized, and are usually more of a dull ache than sharp pain.

AORTIC PAIN

In syphilitic aortitis and aneurysm, there is a dull ache or generally substernal, which may radiate, but is not paroxysmal. Of course there may be added sclerotic conditions of the coronaries with the syphilitic aortitis, which can give the typical pain of coronary disease.

PAIN OF RHEUMATIC FEVER

This has been added by Hartig of Kansas; and he feels that the more intense the attack, or after repeated attacks, the pain is more severe.

There are occasionally other changes, which may in a way simulate heart pain, but which should not be hard to differentiate. Some of

these are: Intercostal neuralgia, neuritis, pleurisy, pulmonary disease, myalgia, mediastinal disease, tumors or diseases involving posterior roots of spinal nerves, locomotor crisis, organic disease of esophagus, functional disturbances of the colon, pneumothorax, impending diabetic coma, bursitis, malingerings, etc.

As to the mechanism of referred pain, Kelly discusses it in this way. The heart muscle is not supplied with pain fibers, and to have pain produced by the heart, it becomes necessary to call into the equation the mechanism of referred pain production, which was worked out by Henry Head. He showed that viscera do not possess tactile and pain sensibility, but are supplied by vegetative nervous system, with fibers which enter dorsal spinal roots belonging to definite caudal segments. Within the cord, these fibers are related to fibers, both motor and sensory, which go to the periphery and carry impulses regulating muscle tone, cutaneous sensibility, and other less understood functions. These nervous system activities are carried on without any of the stimuli reaching the consciousness. However, when inflammation or disease of a viscus occurs, the number and intensity of afferent stimuli from the organ to its cord segment increases and the peripheral motor and sensory elements in the segments, which are in relation with the sympathetic supply to the diseased organ, are so stimulated that muscular rigidity in skeletal muscles occurs and pain is felt in the skeletal areas supplied by their cord segments, often accompanied by hyperalgesia of the skin. The pain and hyperalgesia are always distributed according to the segmental supply, and not according to the distribution of peripheral sensory nerves. This is similar to the distribution of the eruptions in herpes zoster.

Mackenzie, with this work as a basis, found that the area over which pain is felt, and over which hyperalgesia occurs following heart pain, corresponds to the segmental skin areas supplied first, second, third, or fourth, dorsal segments of the cord. More rarely, the pain may be felt higher in the neck, or lower in the epigastric region, showing a spilling over of stimuli into adjacent segments, the heart being supplied by sympathetic fibers—areas from first, second, third, and fourth dorsal segments

also. Thus the distribution of pain in angina pectoris is that of referred pain.

The motor effects are not so clear to observation, but Mackenzie feels that the sense of constriction complained of by many patients is due to spasm of intercostal muscles.

Very frequently patients complaining of precordial pain show nothing on examination, or any history which will throw any light as to the cause. In these cases, electrocardiograph examination often will help a great deal. One author states that in these cases electrocardiograph examinations are of enormous value; and Lidwill points out that in those cases where there is true cardiac pain, even though the heart is quite normal in size and free from murmurs, at least 70 per cent of the patients will give abnormal electrocardiograms, showing that some of them are suffering from coronary narrowing, and others from block of the Bundle or its branches, etc. Also, that those patients who have cardiac enlargement and symptoms of circulatory insufficiency, and who are really suffering from a diffuse myocardial degeneration from arterial narrowing or from multiple foci of low-grade infection within the muscle, give abnormal electrocardiograms in about 85 per cent of the cases.

Hypertrophy of the auricles and comparative enlargement of the right or left ventricle can also be demonstrated by the electrocardiograph. It will verify the presence of mitral stenosis, and determine presence of heart block long before it is suspected. It will show up lesions of the Bundle of His, which cannot be determined by any other method. Kahn shows the electrocardiograms of relative unimportance in the clinical diagnosis of angina pectoris. But he says, in cases of clinical angina pectoris, any abnormality of the electrocardiogram, however trivial, may be significant. The alteration in the form of the T wave following a minor attack is a gradual one, except where there is massive occlusion, so that every alteration is important. In order that the electrocardiogram should serve best in diagnosis, frequent records should be made at intervals. In his series of 330 cases of typical angina pectoris, he finds that 40 per cent showed negative electrocardiograms during entire period of observation. He concludes that, in the evalua-

tion of electrocardiogram as an aid in the diagnosis of angina pectoris, it must be remembered that negative findings must be dismissed from consideration, while even trivial findings may have weighty significance in diagnosis.

Cooksey and Freund, in a study of twenty-four cases of acute coronary occlusion, found positive cardiograms in every case.

In this paper an attempt has been made to show some of the causes of cardiac pain, and to stress the point that a clear diagnosis must be made, if possible, using every means at our disposal for the patient's well-being, whether pain is caused by a functional non-cardial condition or by a true serious organic disease of the heart or of the arteries.

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INFANT FEEDING

By ROBERT E. WRIGHT, M.D., East Orange, N. J.

Presented as part of a panel at Babies' Hospital-Coit Memorial during the Clinic Conference of The Medical Society of New Jersey, October 7th, 1938.

For the past three and one-half years I have been conducting a survey of the problem of infant feeding at the Homeopathic Hospital in East Orange. This hospital is unique for the purposes of such a study because here the clinic, or ward, type of patient parallels as nearly as possible the private patient in financial and home status. Over 1000 cases have been considered in the survey and the method of selection was as follows: The Record Librarian selected at random from the hospital files an equal number of clinic and private cases from among the normal infants delivered each month. In planning the survey the clinic cases were compared with the private cases as to the amount of weight gained in each group under various types of feeding.

COLOSTRUM

Let us first consider the first milk or colostrum. Opinions as to the value or uses of this substance are as diverse as the number of authorities who are consulted. Most agree on little save the chemical composition and the phagocytic action of the "colostrum corpuscles". But there is one point which has been observed and which seems to be true, and this

is, that this substance has a function in preparing the new-born infant's alimentary tract for the reception of the more complex feeding which is to follow in a few days. Many speak of the laxative action of colostrum, and its possible antibody content, but whatever its function, it has been noted in the survey that the loss of weight which accompanied the first three days of life, and colostrum feeding, was not any greater among those infants fed on colostrum exclusively and those who received some type of preliminary supportive feeding. (By preliminary supportive feeding is meant that some artificial feeding is given to fortify colostrum feedings.) Therefore, it is safe to conclude that there is no necessity to support this unknown but useful substance with which nature has endowed the lactating mother.

BREAST FEEDING

As the survey progressed, one outstanding point was noted, and that was the tendency of the private physician to augment the breast feeding with some type of artificial feeding. In some cases this was, of course, due to the failure of the maternal supply; but for the greater part, I believe, due to a desire on the

part of the attending physician to send home from the hospital a gaining, well-fed baby. While on the other hand, the doctors attending the clinic cases had uppermost in their minds the object of keeping feeding as simple as possible. To this end every effort was made to use breast feeding alone, and in the entire survey 70 per cent of these babies were so fed, while in the private group only 28 per cent of babies were entirely breast fed. In other words, the private doctor felt that in over 65 per cent of his cases, it was necessary to support in some way the feeding at the breast. This tendency is also shown in other hospitals where no attempt is made to note the baby's progress on the breast, and all infants regardless of their needs are immediately placed on a complementary regime.

To return to the survey, and keeping in mind the parallel between the two groups, the question arises as to why this discrepancy should arise. Does the private physician feel that a rapid increase in weight is necessary to the successful pediatric care of the newborn? If so, let him discard his complementary formulae, and use in 70 per cent of his cases entirely breast feeding. For looking further into the survey we find that, in weight gained, the clinic babies on breast feeding entirely gained an average of 6.5 ounces per baby, while an almost similar number of private cases on complementary feeding gained only an average of five ounces/baby,—a difference of 1.5 ounces per baby in favor of the entirely breast fed. Naturally enough, those few private cases which were entirely breast fed showed an average gain as great as that of the clinic breast-fed babies. Surely nothing shows more the superiority of breast feeding than this.

SYSTEM OF BREAST FEEDING

The reason, I believe, for this tendency to rush into complementary feeding on the part of the private physician is a lack of systematizing breast feeding. In the clinic group the following system for breast feeding was used:

1. The infant was put to breast eight hours after delivery.
2. For the first twenty-four hours the infant was nursed at a four-hour interval with five-minute nursings on each breast.
3. For the second twenty-four hours the infant was nursed at a four-hour interval, with ten-minute nursings on each breast.
4. The infant was nursed thereafter for twenty minutes, using the four-hour interval for infants over seven pounds birth weight, and a three-hour interval for infants under seven pounds birth weight.
5. If an infant on four-hour schedule failed to gain, he was placed on a three-hour regime.
6. Complementary formulae were given only after the infant failed to gain on the three-hour schedule, and had lost ten per cent of its birth weight.

Surely this is less complicated than the early use of some combination of breast and artificial feeding. Further than this, in order that this system be effective, it requires strict individualization of the cases, a thing which is so very often neglected where the newborn is concerned. And what is probably even more important than the foregoing is that it tends to give the infant a normal, natural start in life as far as feeding is concerned. It is this normal natural start in life which we hope will serve as an adjuvant in the attempt to reduce the neonatal mortality.

CRITERIA OF TUBERCULOUS ACTIVITY IN CHILDREN HAVING A POSITIVE TUBERCULIN TEST

By E. HARRISON NICKMAN, M.D., Atlantic City, N. J.

Read before the Section on Pediatrics of the Annual Meeting of The Medical Society of New Jersey,
June 7, 1939

Because of the unreliability of physical signs, the diagnosis of early active tuberculosis in ambulant children is difficult.

Because of the importance of early diag-

nosis, criteria for its establishment are necessary; and among those procedures more commonly used for the purposes are, 1, the physical examination; 2, the x-ray; 3, the Mantoux

test; 4, the monocyte-lymphocyte ratio; 5, the sedimentation rate; and 6, the nuclear index (Boerner).

These six procedures were chosen as being the most likely, individually or collectively, to detect tuberculous activity. They were applied to 168 cases, observed over a period of two and one-half years, in the Atlantic City Hospital Tuberculosis Clinic, in order to establish, if possible, their comparative efficiency.

MATERIAL

These cases represented the average run of children who came to the clinic. All were known to be contacts. There were 100 negroes, and sixty-eight whites. The oldest case studied was sixteen years of age, the youngest, twenty-three months,—average age, 9.8 years. Males and females were equally divided. The average weight gain per year for each child was five pounds, which is normal. Pulse and respiration in all cases were within normal limits. The cases were unselected except for the exclusion from the series of those children who had definite acute infections, such as tonsillitis, Vincent's angina, and bronchitis.

The value and limitations of the six procedures which were adopted are fairly well known. However, a brief summary of each will assist in interpreting our findings.

Physical Examination.—A diagnosis of most phases of primary tuberculosis cannot be made by physical examination. Usually only diffuse areas of infiltration of the lung parenchyma give rise to abnormal physical signs, and these are seldom found in our clinic, since it deals only with ambulant cases.

Mantoux Test.—The Mantoux test has been known for a long time as the very first indication of the presence of a tuberculous invasion of the body; but a tuberculin test does not necessarily indicate the presence of tuberculous infection. The tuberculo-toxin sensitizes the body tissues to produce an allergic sensitivity; and when a tuberculin test is done, this sensitivity is demonstrated by the local skin reaction. The degree of response to the tuberculo-toxin indicates either (a) the degree of sensitivity of the individual, or (b) the degree of invasion of the body. Hence, tuberculin-posi-

tive reactions indicate exposure and contact, and reveal those children who may be or who are likely to become actively tuberculous; and therefore those who should be observed with particular care.

X-ray.—The x-ray is a valuable aid in determining the presence of pulmonary tuberculosis. However, in contrast to the tuberculin test, which is highly sensitive, the x-ray is much less so in detecting early tuberculous lesions, due to the fact that the primary infection in the lung parenchyma usually subsides within a short time, leaving little or no evidence that infection has taken place, and also because the initial lesion may be too small to notice. Moreover, the x-ray cannot definitely distinguish between active and non-active cases.

The primary parenchymal lesion is usually accompanied by an involvement of the hilar lymph nodes, which remain enlarged after the parenchymal lesion has subsided; and it is from their presence that we suspect the existence of a primary tuberculosis. However, tuberculosis is not the only cause of enlarged hilar lymph nodes.

Sinusitis, abscessed teeth, syphilis, malignancy, measles, pertussis, and other conditions may produce similar changes in the x-ray film. Despite difficulties of interpretation, the x-ray has a definite place in the diagnosis of early tuberculosis; particularly in demonstrating the progress of the disease in a series of films taken over a period of time.

Sedimentation Rate.—The sedimentation rate has been used in a number of conditions to determine the degree of tissue destruction going on in the body. The test consists in observing the rate at which the cells separate from a sample of blood to which an anticoagulant has been added. A great mass of literature has accumulated with regard to the value of this test, but the opinions are by no means unanimous as to its worth. It is believed to be of great value in segregating active and inactive cases of tuberculosis. The sedimentation test, however, must be interpreted with great care, since it will neither indicate nor suggest the type of condition which is present. The sedimentation test will show activity indiscriminately in tuberculosis, rheumatic or respira-

tory infections, gingivitis, and pregnancy. Consequently, before it can be used to interpret activity for one condition, all other conditions must be eliminated.

Monocyte-Lymphocyte Reaction.—Cunningham, Sabin, Sugiyama, and Kindwall showed that the monocyte-lymphocyte ratio in the peripheral blood may be taken as an index of the progress and extent of the disease in bovine tuberculosis experimentally induced in rabbits. Flinn and Flinn and others have published a blood study of patients in which they have confirmed the monocyte-lymphocyte ratio as being of aid in studying the progress of the disease. Others, however, have not been able to confirm it so fully.

It has been pointed out by Medlar and others that neutrophils appear in the blood in increasing numbers during caseation and cavitation. During the period of active spreading, when areas of caseation are present, the percentage of young neutrophils increases, causing a shift to the left, according to Arneth.

The purpose of the Arneth test, the same as that of the monocyte-lymphocyte ratio, is to give one an idea of what is going on in the leukocytic system at the time. The Schilling hemogram is an improved modification of Arneth's work, and has the same purpose.

Nuclear Index.—In our study we used a further modification known as the nuclear index (Boerner), which is derived by deducting the number of immature neutrophils from the total number of neutrophils, and dividing the result by the number of immature cells. The lower the number the greater the shift. Above fifteen is considered normal; 10-15, a slight shift; 5-10, a moderate shift, and below five, a marked shift.

A great difficulty of interpretation of the six tests which have been described is that *all* are non-specific to a greater or lesser degree. They indicate only response to stimuli, without any differential significance as to the nature of the stimuli. The stimulus may be very mild and yet it may elicit a response. Hence, the nature of the stimulus must be judged from the sum total of all available data.

The primary purpose of this study was to determine the value of these various procedures in the study of tuberculin-positive children, as

a means of selecting, if possible, those who were really tuberculous, and who were not; and whether or not those infected were active, or quiescent.

RESULTS

The *Mantoux test* was positive in every one of the 168 cases, there being 68 one plus, 68 two plus, 56 three plus, and eight four plus Mantoux. Thirty-two of the cases which we had followed for more than one year had two Mantoux tests done.

The *x-ray* showed no demonstrable lesion in 104 cases; fifty-one cases which were suspicious of primary tuberculosis; and thirteen cases of reinfection type tuberculosis.

The sixty-four cases in which x-ray findings were apparently positive had insufficient chest signs to warrant a diagnosis of tuberculosis based on physical examination alone. One case, a colored male, twenty-three months of age, had a reinfection type of chest lesion as shown by x-ray; no chest signs; a severe dactylitis of nearly all of the fingers of both hands; and an epiphysitis of both wrists.

The *sedimentation* rate found six children with slight or moderate activity, of whom four had upper respiratory infections, which we felt accounted for the increased rate. Physical signs and x-rays were negative for tuberculosis in these four cases. The other two cases, both colored females, ten and twelve years of age, had reinfection type of chest lesions as shown by x-ray. It may be worthy of note that the child with dactylitis mentioned above had repeatedly inactive sedimentation rates.

Thus, out of sixty-four cases with positive x-ray findings only two gave evidence of active sedimentation rates which might be considered due to tuberculosis. These figures seem to indicate that a sedimentation rate determination, as a routine procedure, is not helpful in diagnosing early tuberculosis in the majority of cases. However, this assumes that all the cases with positive x-ray findings were actively tuberculous. Failing any supportive clinical evidence of active tuberculosis, we cannot assume that the test is of no value, as further follow-up of these cases may find a greater number of active sedimentation rates.

We could draw no conclusions from the

monocyte-lymphocyte ratios of our series. This was probably due to the fact that there is a changing percentage of lymphocytes and leukocytes from birth to adult life, making it difficult to estimate slight changes during childhood. The lymphocyte percentage of sixty at birth, forty-five at the age of four to five years, and thirty in adult life shows a gradual decline which causes any individual estimate to be attended by considerable inaccuracy. This is also true of the neutrophils.

The *nuclear index* proved to be very sensitive in that a large percentage of our cases showed abnormal shifts. Only four blood counts in the entire series showed no shift, and each of the four was in cases having only one plus Mantoux with the weakest dilution (.01 mgm.), and negative x-rays. A slight shift was shown in twenty counts; a moderate in 112; and a marked shift in 132 counts. A control series of blood counts was done on thirty apparently normal, healthy children to determine the normal average nuclear index. The control figure fell into the class of 10-15 band forms—that is, slight activity.

On the basis of their being within normal limits, the twenty-four counts in our series which showed either no activity or slight activity were disregarded and not considered active. The remaining 244, representing 151 cases, showed either moderate or marked activity. A comparison of the group having active nuclear indices with the group having positive x-rays showed that forty-eight of the fifty-one cases with x-rays positive for primary tuberculosis, and eleven of the thirteen cases with x-rays positive for reinfection type of tuberculosis, had active nuclear shifts. Three primary and two reinfection types did not. Thus, the majority of cases having positive x-rays also had active nuclear indices. However, as the majority of cases in the entire series showed nuclear shifts, no significance could be attached to this comparison.

An interesting and unexpected parallel was found between the degree of severity of the Mantoux test and the nuclear index. The twenty cases with slight shifts had one or two

plus Mantoux, sixteen of which were with the stronger testing solution (one mgm.) and four with the weaker (.01 mgm.), but every one of the three and four plus Mantoux had moderate or marked shifts. Hence, there appears to be a definite parallel between the degree of severity of the Mantoux test, and the amount of shift as determined by the nuclear index.

It may be noted that at least one week elapsed in every case between the performance of the Mantoux test, and the nuclear index. However, as this parallel was an accidental finding, no attempt had been made during the course of the study to see whether the tissue reaction of the skin test had entirely gone before the nuclear index was done. A future study is contemplated to settle this question.

CONCLUSIONS

1. The findings of this report must be considered only as a basis for future studies for the following reasons:

a. Because our findings are based upon a small group of children, some of whom had but one examination in each of the procedures studied.

b. Because clinical signs of tuberculosis may take years to develop, and our study extended over a comparatively short period.

These reasons apply especially to such non-specific procedures as the sedimentation rate and nuclear index.

2. When all other possible reasons are eliminated, the nuclear index seems a valuable aid in suggesting the possibility of early tuberculosis, and hence the necessity for observation.

3. The series suggests that when children show positive tuberculin tests and nuclear shift without apparent cause, they should be periodically observed until tuberculosis can be proved or disproved by physical examination and x-ray.

4. A possible relationship exists between the severity of the tuberculin reaction and the degree of nuclear shift, if there are cases in which all vestiges of the tuberculin reaction are gone but a shift is still present.

STANDARDS OF IMMUNIZATION AGAINST DIPHTHERIA

A report from the Committee on Child Health,—one of the eleven advisory committees to the Sub-Committee on Public Health of the Welfare Committee

By L. CHARLES ROSENBERG, M.D., Newark, N. J.

This report expresses the conclusions of the Committee on Child Health regarding a standard uniform method which a family doctor can follow in immunizing children in private practice and in clinics.

In order to induce active immunity three antigenic materials are available:

1. Plain toxoid,—a mixture of diphtheria antitoxin and toxin, with a very slight excess of toxin.

2. Alum-precipitated toxoid. The toxic portion of the toxin is destroyed, leaving the immunizing portion free for antigenic activity.

3. Toxin-antitoxin mixture.

1. PLAIN TOXOID

There seems little doubt, judging from the reports in the current literature, that, insofar as the comparative efficiency of the substances is concerned, the plain toxoid is the superior agent. Laboratory and clinical studies have demonstrated that this particular antigenic material is superior to all others in the persistence of immunity achieved by its use. FitzGerald and his collaborators,¹ Strong,² Benjamin and his collaborators,³ Pansing and Shaffer,⁴ and many other leading authors testify as to its superior efficacy.

2. ALUM-PRECIPITATED TOXOID

When this product was introduced by Glenny in 1930,¹⁷ it was hailed as the ideal antigen because only one dose was believed necessary to produce immunity, and because 95 per cent of the children were rendered immune in the comparatively short period of one month. However, its efficacy was not questioned for some time, that is, not until 1935, when Fraser and Halpern⁵ reported on a group of cases receiving the one-dose alum toxoid, in which they showed that "After one year, only 19 per cent of the alum group remained above the one one-hundredth level". Following this astonishing announcement, there were other sim-

ilar reports: Park,⁶ Ramon,⁷ and Bradley⁸ presented conclusive evidence that, though granted that the one-dose alum-precipitated toxoid really does confer a most rapid immunity, the duration of immunity is so brief as not to justify the product's continued use. This rapid loss of immunity following the one-dose toxoid must be stressed. It should be known generally that attempts at immunization by the single-dose method of toxoid, while attractive and tempting, have led to the unpleasant discovery that there was no permanency of the immunity conferred.

Even those who adhere to the practice of using the alum-precipitated toxoid as the antigen of choice seem now to be giving up the one-dose method, and are coming to realize that the multiple-dose immunization is the better method.

Furthermore, the advantage of the two-dose over the single dose method is based upon the recognized and well-known fundamental immunologic phenomenon of a secondary stimulus of the antigen, resulting in a more permanent and better antitoxic response than a primary stimulus alone would have accomplished.

Besides these objectionable features, this preparation has other disadvantages. At times one has to contend with tender nodules persisting at the site of the injection, and with occasional abscess formation in the case of older children. Furthermore, in the use of the alum-precipitated toxin, if one should use a fine needle, very little of the precipitate (which is, of course, the active immunizing portion of the material) would be injected.

3. TOXIN-ANTITOXIN

Comparing toxoid, and toxin-antitoxin mixtures, the percentage of persons immune after the use of the diphtheria toxoid has been shown to be considerably greater than that which has been obtained after the injection of the toxin-

antitoxin mixture (popularly known as the T. A. T. mixture). A further disadvantage of the T. A. T. is its instability, since it has a tendency to deteriorate on standing, with the result that its antigenic value is impaired. This statement is particularly true of the available commercial preparations, but it does not apply to those that are strictly fresh.

THE PREPARED MATERIAL

It is obvious, therefore, that the consensus of opinion is distinctly in favor of the *plain toxoid* over and above all others, because of its high level of antitoxic response following its administration and because the immunity derived is lasting.

TECHNIC

With reference to the accepted technic in the administration of the plain toxoid, there exists some controversy amongst authorities as to the best plan. However, in a careful study of reports in the literature, one cannot help feeling that the trend of the majority is as follows:

1. Immunization is undertaken at about nine months of age.

2. The dosage recommended is one cubic centimeter at each inoculation, with a three-week interval between the doses.

The Schick test should be performed four months after the completion of the immunization. It is not necessary to wait six months.

AGE

The most desirable age at which to start the injections is *nine months*, because if injections are given before this time, a considerable proportion of the infants retain their passive immunity. The retention of the antitoxin in the blood, it has been shown, will interfere with successful immunization. The Committee on Immunization Procedures of the American Academy of Pediatrics is in accord with this view. It must be noted in this connection, however, that, should one desire to begin the injections under nine months of age, it can be done if one will rule out the persistence of this natural immunity by preliminary Schick test, only the positive reactors being given the inoculation.⁹

NUMBER OF INJECTIONS

With regard to the number of injections that result in the most effective and persistent immunity, if one follows the reports of the Montreal and Toronto workers, one cannot but be convinced³ that "A higher degree of immunity, as gaged by the Schick test, is induced by three doses than by two doses of toxoid". So far as dosage is concerned, in using the plain toxoid, the tendency is toward one cubic centimeter in amount at each inoculation. It should be noticed, however, that the interval between the injections can be varied within fairly wide limits without interfering with the resulting immunity.

SCHICK TEST

Reference may now be profitably made to certain essential aspects in performing the Schick test, to prevent incorrect conclusions from being drawn. Most of the material now available for Schick testing is marketed ready for use, without need of further dilution. It is a stable solution of diphtheria toxin devised by Bunney and his co-workers.¹⁰ It does not have to be diluted, as does the U. S. P. product. It is safe, reliable, convenient, and gives true Schick reactions.¹¹ Before using this Schick test material, we must be assured that it has been stored at proper temperature and protected from light, and we must make certain that the exact specified amount of toxin is injected (for otherwise, obviously, the reaction may be negative even though the individual is susceptible).

The test is done in the usual way by injecting an intradermal dose of 0.1 c.c. into the forearm. The reading of the result is best deferred until the fifth or sixth day, at which time the characteristic appearance may be noted.

One must differentiate between true and false reactions. These pseudo-reactions are differentiated by their earlier appearance, and earlier disappearance. Furthermore, false reactions are not followed by pigmentation and scaling.

Some comment as to whether or not the control test should be done would seem appropriate. Pseudo-reactions are confined chiefly to

the older age group. They are infrequent, and of no significance in infants. For this reason it is not necessary to do control tests in infants and children of pre-school age.

The Syringe.—Finally, for Schick testing one must never use a syringe that has previously been used for the tuberculin reactions, because of the extraordinary adherence of tuberculin to the syringe. This was first noted by Parish and O'Brien.¹² Likewise, should an occasion arise where one decides to do a control test, it is to be remembered *not* to use the same syringe that one used for the actual test.

Reactions.—That reactions from toxoid do occur must be borne in mind. However, reactions are not influenced by dosage but by the age of the subject. In this connection Hayman¹³ notes that the age of the subject is the guide in forecasting possible occurrences of a reaction, there being an increase in reactions with the increase in age.

From a study of the literature it appears that local and general reactions to toxoid in children over five years of age are frequent, and severe enough to warrant caution in its use. For this reason it is best to test for individual *hypersensitivity* to this material. This is determined by an intracutaneous injection of 1/20 dilution of the toxoid in saline, 0.1 c.c. being the dosage, and the reaction is read in forty-eight hours. This diluted toxoid test is frequently referred to as the *Moloney test*.¹⁸

Those individuals who are found to be reacting positively to this test may be immunized with toxoid by the use of material diluted and administered in split doses, thus obviating the disagreeable reactions.

DURATION OF IMMUNITY

From the standpoint of both the practicing physician and the public health officials, it would seem that the most important phase of this entire question of diphtheria immunization is the realization that the *immunity may not be permanent*. It has been a great surprise to learn that the immunity which develops after diphtheria prophylaxis is not always permanent. Its protection lasts for a variable length of time. Heretofore, the immunity has generally been assumed to be lasting, but ex-

perience has proven otherwise. Report after report definitely indicate that not all children retain their immunity after having been actively immunized. A few experiences reported by well-known authorities will serve to emphasize this point.

Benjamin and his collaborators³ cite two cases, as follows:

Of all the children immunized by us who gave a negative Schick reaction, one girl acquired diphtheria five years after a test eliciting a negative reaction. She had been given three doses of toxoid, of 0.5, 0.5 and one c.c., respectively, at intervals of three weeks, beginning at the age of one year and eight months, and gave a negative reaction when tested eight months after the last injection of toxoid. *Corynebacterium diphtheriae* was obtained repeatedly in cultures of material from her throat (tonsils), and a test for virulence produced a positive result. The disease was mild and she made an uninterrupted recovery.

Another child, a boy, was said to have died of diphtheria at the age of two years and seven months. He had been given a first dose of 0.5 c.c. when he was one year and eight months old, 0.5 c.c. one month later and one c.c. a month thereafter. His reaction to the Schick test was negative six months after the third injection of toxoid. He died at home after an illness of two days, forty-two days after a negative reaction to the Schick test had been elicited. No laboratory confirmation of the diagnosis was obtained.

The Department of Health of the City of New York¹⁴ reports that, of 668 cases of diphtheria occurring during 1936 in children under fifteen years of age, 249 were in children who had received immunizing injections. In tabulating these 249 cases according to the period of time elapsing between the preventive inoculations and the development of diphtheria, it was found that the number of cases rises steadily with the length of this interval.

Schwartz and Janney¹⁵ state: "In a recent retesting of 145 of those children who had received toxoid and had shown a negative Schick test six or seven years previously, 22 per cent showed a reversion to a positive Schick test."

Fraser and Halpern also recite a similar experience.¹⁶

From the study of reports on the duration of protection following active immunization, it is obvious that there is a gradual decline, so that approximately from 10 to 20 per cent of children lose their antitoxic immunity five

years after artificially produced immunity. Parents must be informed of the fact that this artificially induced immunity is not always permanent.

I say this because so many lay people have a false sense of security in thinking that their children are fully and permanently protected after the immunization procedure is completed; when in reality we know a good percentage of the children do not retain their immunity for many years. Those of us, therefore, who assume the responsibility of immunizing children must take cognizance of this fact, and consider a plan for more secure protection from diphtheria.

CONCLUSIONS

The modern trend of opinion among health officials is to advocate immunization of the child at about nine months of age; followed by Schick retesting on entering school; and the administration of another cycle of injections to children that have lost their immunity. It is believed that this is probably the most

logical plan that may be adopted in line with our present information on the subject.

Incidentally, this procedure would be similar to the plan adopted in various European countries for vaccination against smallpox, the first vaccination being done in infancy, and a second on entering school.

It must be said that, while the last word on the subject has not yet been written, the following would seem from a practical viewpoint to be the wisest and safest procedure, in the opinion of various health officers:

Use the plain toxoid as the material of choice.

Give two injections as a minimum; but three are preferable.

Begin the injections at about nine months of age.

Check this immunity four months later by a Schick test.

Re-test the children on entering school as to the persistence of their immunity.

Reinoculate those children found to have lost their protection.

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COMMON COLDS

By YALE KNEELAND, JR., M.D., New York, N. Y.

Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey,
June 7, 1939.

Of all the acute infectious diseases in the temperate regions of the world, surely the common cold is most ubiquitous. Moreover, while the malady itself appears to be a relatively minor one, the amount of ill-health which it causes, directly and indirectly, is enormous. It is no wonder then that a great amount of effort has been directed toward the discovery of some practical solution of the cold problem.

THE INFECTIVE AGENT

The problem is a many-sided one, but our interest has been chiefly devoted to the nature of the infectious agent, or agents, which are primarily responsible for the disease. That the common cold is primarily infectious in nature, I think, has now been established beyond any doubt. Careful studies of small isolated populations have quite definitely proved this. The nature, then, of the infecting agent, while it is only a portion of the whole entity of acute upper respiratory disease, is perhaps the most important part of a complex problem.

If one attempts to summarize the researches which have been conducted in the past twenty years on this subject, one may begin by saying that the human naso-pharynx is inhabited by a group of microorganisms, most of which are probably harmless. There are, however, certain other organisms which are potentially pathogenic. At times these may exist in entirely healthy individuals; but there is every reason to believe that these potentially pathogenic organisms may be activated by an acute cold, after which time they probably function in two ways: First, they increase the severity and are responsible for the suppurative complications of the common cold; and second, they become endowed with the capacity to disseminate themselves amongst the population at large.

In spite of the obvious importance of these pathogenic bacteria, it is now quite generally agreed that they are not the primary etiological agents of the common cold. The primary

agent is, in all probability, a filterable virus. Whether there is a single filterable virus, or several immunologically distinct viruses of the common cold, is not yet known. A considerable amount of information has been accumulated during the last ten years as to the nature of the cold virus, but much yet remains to be learned. One thing I think can be fairly definitely stated, and that is that the cold virus, or viruses, are probably not identical with the virus of human influenza, which has been subjected to so much study, both here and abroad.

THE RESISTANCE OF THE PATIENT

Having thus outlined broadly the nature of the infectious agents of the cold, and indicated the rôle that they play, one can proceed to the question of how the situation may be modified to limit the activity of these agents. In the first place, it is fairly obvious that a disease producing only a transitory immunity and to which nearly everyone is susceptible, cannot be controlled by the public health methods which have been so conspicuously successful in infectious diseases of other types, such as those which produce a life-long immunity, and those of which the carrier is such that lines of communication can be interrupted. It is therefore necessary to attempt some method of increasing the resistance of the susceptible individual.

Attempts to increase this resistance may be divided into three general classifications. First, we have general measures aimed to increase resistance to disease. These are undoubtedly laudable and probably have some effect in mitigating the damage done by colds. However, there is no clear-cut demonstration that a state of good nutrition, adequate general hygiene, or adequate vitamin intake will afford any insurance against an individual acquiring an acute cold.

Secondly, there are local measures, that is to say, attempts at eradicating diseased foci in the upper respiratory tract, and correcting ana-

tomical abnormalities. Here again, while these procedures are undoubtedly of some benefit, they do not afford protection against the common cold.

Thirdly and lastly, we come to the specific measures. By specific measures I mean those which aim to enhance the individual's specific resistance against the agents referred to above. The obvious desideratum here would be to create an ample immunity against the cold virus itself, as this seems to be the keystone to the arch of acute respiratory infection. Unfortunately, up to now, attempts at this have been unsuccessful.

Thus, all that remains is the possibility of increasing the individual's resistance against the secondary bacterial invaders which probably are responsible for some of the severity and all the complications of the common cold. Our method of doing this, naturally, is the use of bacterial vaccines. These, as everyone knows, have been employed over a long period of time, and have given rise to many conflicting opinions as to their merit.

A bacterial vaccine, to be effective, should consist of the one specific organism or organisms by which the individual is destined to be attacked. As this cannot be known in advance, at least in most cases, one must of necessity have recourse to mixed bacterial vaccines prepared from stock cultures. Now, it is fairly obvious that the more complicated a vaccine, the less resistance will be generated to any of its components; and as the flora of the upper respiratory tract is an extremely complicated one, too much cannot be expected in the way of immunity from the use of stock vaccines. Moreover, it has been frequently shown that the use of stock vaccines in large groups of unselected individuals usually fails to result in any particularly important benefit. From our

own experience, however, we have reached the conclusion that mixed bacterial vaccines have a real though limited sphere of usefulness. If the individuals so treated are rigorously selected from the group that is extremely susceptible to the complications of colds, then definite, though by no means complete, protection can be achieved provided the vaccines are given patiently over a long period of time. This highly susceptible group includes adults with a strong tendency to recurrent sinusitis and bronchitis, and children who, during each winter, are ill for considerable periods of time with fever due to upper respiratory infections, together with such complications as otitis media.

TREATMENT

As far as the treatment of colds is concerned, once the infection has started, there has been very little advance in recent years. Encouraging results have been reported by means of the use of codeine and papaverine, but in our own experience, these drugs seldom succeed in aborting a cold. The use of local antiseptics has been very largely discarded, and the employment of local applications designed to shrink the mucous membrane is chiefly of value in the later stages. There is no adequate proof that any of the other various measures in vogue at one time or another really are effective.

One thing it is important to bear in mind,—the common cold is a more serious disease in childhood than it is among adults. Moreover, children are susceptible to greater complications. In early childhood, therefore, the common cold is a disease which should be treated by strict bed rest. If this simple and fundamental remedy could be applied to adults as well, it is probable that the gravity and duration of colds would be greatly lessened.

THE GLUCOSE TOLERANCE TEST IN RECURRENT INFECTIOUS INTERTRIGO

By C. C. CARPENTER, M.D., Summit, N. J.

Read before the Summit Medical Group, February 15, 1938.

The intertrigos may be placed among the most annoying of skin troubles because of the excessive pruritus that accompanies the inflammation in these tender areas. For this reason recurrent attacks are dreaded by the patient and become a problem to the doctor, who finds each succeeding episode more intractable to treatment. In endeavoring to analyze the reasons for such repetitions, a study of the patient's glucose metabolism was found of help in alleviating the acute manifestations as well as in the prevention of recurrences.

For purpose of classification, Weidman¹ divides this group of diseases according to the etiology into:

- I. Maceration Group—Physical and chemical intertrigos
 1. Maceration
 2. Mechanical
 3. External irritants and chemicals
- II. Infectious intertrigos group
 1. Bacterial-streptococcus, staphylococcus, etc.
 2. Blastomycetic (yeasts)—cryptococci, saccharomycetic, etc.
 3. Hyphomycetic (Tineas)—epidermophytic, trichophytic, etc.

Of these, we are only interested in those of the second group, and particularly with those produced by the yeast and tineas. The areas most frequently affected are the interdigital spaces of the feet, hands, the paronychia folds, corners of the mouth, the inframammary, axillary, and inguinal folds, and the natal cleft. Many times two or more of these sites may be involved at the same time, thus indicating the infectious nature of this process.

It has been recognized for some time that yeast and tinea infections are associated in some way with errors in carbohydrate metabolism and are particularly prone to occur in the Jewish race where the incidence of diabetes is high. Cornbleet,² in studying the self-steril-

izing powers of the skin, proved that normal, dry epithelium has an inhibiting effect on various bacteria which have been smeared on its surface. Moisture, on the other hand, favors bacterial growth, and for this reason the skin folds are less able to inactivate microorganisms than are normal, dry, cutaneous surfaces. This function to suppress growth of infectious organisms is greatly lessened if the skin is pathologically changed.

The same author² found in sweat a reducing substance which is allied to sweat-lactic acid and occurs in higher concentrations in the perspiration of individuals with intertrigo. The amount of this reducing substance can be increased by excessive sweating, the feeding of glucose, and by the ingestion of certain drugs. It is also found in large amounts in the dry residue washed from inflamed intertriginous folds. Carbohydrate dietary restriction will lessen the surface quantity of this substance. These studies confirm Weidman's belief¹ that the infectious forms of this disease are primarily intertriginous; and later, secondarily, involve other parts of the body.

Any individual who has a chronic, relapsing form of intertrigo should be carefully investigated to determine if there is any defect in his carbohydrate metabolism. A simple blood sugar is not sufficient, for it may be well within normal bounds. Campbell,⁴ in studying sugar metabolisms of patients with pruritus, outlined a form of glucose tolerance test which would indicate an abnormally delayed assimilation of carbohydrates. He gave, by ingestion, 100 grams of glucose on an empty stomach, and then took blood sugar readings at one-half, one, two, and two and one-half hours following. If the average of these tests is above 120 mgs./100 cc., he considers an abnormal delay is present and carbohydrate dietary restrictions should be enforced.

CASE 1

M. P. G., a Jewish housewife, seventy years of age, was first seen by me in June, 1934. At that

time she had a pruritic lichenified eruption of the groin, inframammary region, occiput, and dorsal surfaces of the hands. There was, in addition, a hypostatic eczema on both legs. Her skin condition had started in the inguinal folds six years prior to being seen. It had gradually spread to the other locations in the next two years. During this period she had been under various forms of therapy, including weight reduction and the removal of a kidney stone and a chronic appendix. Local treatment had been of no avail except to help control the pruritis. The family history included two diabetics, and several with allergic manifestations.

Physically, this patient was markedly overweight, which made possible large areas between the redundant skin folds. These areas presented many erythematous, macular lesions of various sizes, with a superficial, moist scale. Repeated searches for fungi were unproductive, as is so frequently the case in these individuals who have been using local medication over a long period of time.⁵

Results of her glucose tolerance test were as follows:

Blood sugar prior to ingestion of glucose	100 mgs.
Blood sugar ½ hour after ingestion of glucose	160 mgs.*
Blood sugar 1 hour after ingestion of glucose	150 mgs.*
Blood sugar 2 hours after ingestion of glucose	140 mgs.
Blood sugar 2½ hours after ingestion of glucose	100 mgs.
*Sugar present in urine. Average.. 140 mgs.	

This patient was placed on a low carbohydrate diet, and was given x-ray treatments and drying types of antiparasitic medication locally. Her improvement was almost immediate, and continuous, and she was not seen again until fourteen months later, at which time she reported no further recurrences and she was still adhering to the diet.

CASE 2

G. H., a white male, aged sixty-five years, presented a pruritic, moist eruption in the inguinal region, of four months standing. During this time he had received many types of local medication which only caused a further aggravation of his condition. Past history revealed an attack of a similar nature thirty years before, and at one time in his boyhood he had been found to have had a "touch of diabetes".

There was a large, moist, purplish plaque, the size of the palm of a hand, extending above and below Poupart's ligament. Many surrounding satellite macules were present with the same livid color and a fine adherent, scaly border. These were scattered on the upper thigh, lower abdomen, and the scrotum. A few lesions were found in both axillae. Microscopic scrapping from the original plaque, as well as from the satellite macules, revealed the presence of many yeast organisms.

Results of the glucose tolerance test:

Blood sugar prior to the ingestion of glucose	118 mgs.
Blood sugar ½ hour after ingestion of glucose	205 mgs.*
Blood sugar 1 hour after ingestion of glucose	200 mgs.*
Blood sugar 2 hours after ingestion of glucose	185 mgs.*
Blood sugar 2½ hours after ingestion of glucose	105 mgs.
*Sugar present in urine. Average.. 160 mgs.	

After a week's rest in bed, a diet low in carbohydrate, and small daily doses of insulin, the pruritus entirely ceased, the inflammation had practically subsided, and the patient remarked his condition was the best it had been in three months. Since that time he has been extremely cautious with his diet and only occasionally has small remissions which are easily controlled with local medication.

CASE 3

Mrs. H. A., a white female, aged thirty years, was first seen in October, 1936, with a typical, mycotic erosion between the fingers of both hands. This had begun a year prior to being seen and had been associated with a paronychia of two months' duration. Her hands had to be in water a great deal as she did all her own housework. No other intertriginous areas were involved. In the past year the eruption had healed and reappeared several times. Her mother was under treatment for diabetes.

The glucose tolerance test, performed after the ingestion of 100 grams of glucose, gave the following results:

Blood sugar prior to the ingestion of glucose	98 mgs.
Blood sugar ½ hour after ingestion of glucose	210 mgs.
Blood sugar 1 hour after ingestion of glucose	135 mgs.
Blood sugar 2 hours after ingestion of glucose	125 mgs.
Blood sugar 2½ hours after ingestion of glucose	88 mgs.
Average.. 139 mgs.	

A low carbohydrate diet was given to this patient, and a gentian violet cream was used locally. Oddly enough, the paronychia involvement was the first to heal, and the interdigital involvement was the last to clear. This patient has had no further recurrences in a year and she still adheres to the diet.

DIAGNOSIS

Infectious intertrigo may be easily confused with both the mechanical forms and also unrelated dermatoses which may have selected this site, and then, through maceration, scratching, and irritating therapy, have changed their clinical picture. Therefore, it is necessary to

do careful, repeated, and occasionally provocative, mycological studies,⁵ as well as a careful inspection of the entire, cutaneous surface of these patients, to be sure that no primary lesion may be overlooked which would give the clue to a possibly unrelated dermatosis.

TREATMENT

In those cases with an abnormal glucose tolerance test, indicating a delayed assimilation of carbohydrates, there should be a reduction

in the carbohydrate intake. In a few selected cases insulin may be necessary, in low dosages, until the acute manifestations are under control.

So far as local medication is concerned, Howles⁶ points out that no rational plan can be laid out, but each stage must be managed differently; and patience and persistence, in any mode of therapy adopted, are indispensable. In addition, prophylactic measures should be carefully explained to these sufferers.

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FUNCTIONAL DISORDERS OF THE COLON

By SIGURD W. JOHNSEN, M.D., Passaic, N. J.

Read before the Section on Gastro-Enterology at the Annual Meeting of The Medical Society of New Jersey, June 8, 1939.

The subject of functional disorders of the colon is most difficult to present. In the first place, we are unable to define the scope of the subject. In the second place, there is so much confusion and biased thinking on the subject that one is immediately suspected of championing one or the other colonic therapy camps, when he speaks on colonic disorders.

Why another approach? Because after several decades of intensive study of these disorders by many able investigators, there is as yet no unanimity of opinion as to etiology, classification, or therapy of colonic dysfunctions. I do not mean to say that no progress has been made in the study of these cases. Far from it! A great deal of valuable information has been collected from many angles and from different fields,—all bearing directly on colonic functions, disorders, and treatment. As a result of this work many fallacies have been uprooted, and there is a sounder basic conception of colonic function.

The usual approach to a study of the colon is by means of a gastro-intestinal series of

x-rays, barium enema, or proctoscopic and sigmoidoscopic examination. Disturbances of motility are of course the predominant finding. Many of our terms come to us from this type of study. Tonus and spasm are likewise discerned through this medium. A great deal of valuable information has been obtained by this method, and I certainly do not wish to minimize its importance. However, in functional disorders there is so great a variation in what may still come under the category of normalcy, that we are limited in the interpretation of our findings.

We have adopted the method of focusing our attention on the specific organ, and then have attempted to demonstrate pathological changes either gross or microscopic in the tissue. "This", in the words of Franz Alexander,¹ "particularistic concept of medicine" was due greatly to Virchow's great discoveries in the field of cellular pathology. If pathologic changes could not be demonstrated in an organ, there was no disease, or the disturbance was a functional one and not organic. This con-

cept has prevailed for many years. It has almost become a barricade to further advancement in many fields of medicine.

We need not deny the fundamental and tremendously important contributions of men like Virchow, who have been the cause of medicine's greatest era of progress; but neither do we have to stop there and feel that all further progress depends on following the same line of thought.

Instead, therefore, of considering the colon as the disordered organ, let us approach the problem from the standpoint of an individual with a malfunctioning colon. In doing this we are reverting to the earlier studies before medicine became a "particularistic concept dealing exclusively with disease of demonstrable cellular changes in isolated organs".¹

To many of us this will seem to be a step back to the days of prescientific medicine and superstition. We are loath to change our habits of thought and our procedures of diagnosis, but in order to advance, this is just what we have to do at times. If we are honest, we must admit that up to the present we have been unable to meet satisfactorily the problems presented by numerous patients presenting themselves with symptoms and complaints attributable to the colon. We have gone through a veritable siege of colonic therapy procedures which time forbids our mentioning, with results to the patients which have been bitterly disappointing.

Wakefield and Mayo,² in a recent article, have presented a very valuable contribution in approaching this subject as a sociological disorder. They describe an etiological chart which portrays "Social Crisis" as the center of etiological factors in producing these disorders. Surrounding this central factor are the accessory factors of systemic disease, fear of disease, heredity, congenital faults, environment, irregular habits, food allergy, and laxatives.

When we study modern conditions of life today, we must all agree that they are very different from those existing in the past. Certainly, therefore, there must of necessity be changes in our organs to adapt us to these changing environmental factors. These adaptations do occur in most individuals, but in many cases dysfunction of the colon results.

If we consider carefully the case of the sufferer from colonic disorders, we find an individual with a background of maladjustment to present-day standards of living. This may extend as far back as early childhood. Habits of eating, of elimination, of fluid intake, exercise, working, recreation, and thinking are not what they should be, compared with a normal physiological standard.

In order to determine what constitutes a deviation from normal, we must define the normal. Heretofore it would seem that many individuals have accepted the standards proposed by the manufacturers of laxatives. They have agreed that the colon is a sewage disposal plant, and unless the entire contents of this organ are washed out or evacuated daily, dire results are sure to follow. With acceptance of this concept has come a deep-seated fear, that instead of the symptoms being relieved by laxation, they become aggravated. This fear takes on different forms in different individuals. Then too, commonly accepted notions of dietary requirements are far from the actual physiological standards of adequacy. This ignorance makes the sufferer fall an easy prey to all sorts of dietetic fancies and fantasies. Lack of exercise is a common failing with most of us who live a sedentary existence, and this too adds to the difficulties in maintaining normal physiological colonic function.

What, therefore, are the essentials in order that a normal individual may maintain normal colonic function? First, an adequate diet. I wish to submit for your consideration, a detailed specimen diet for an average normal male adult of middle age doing sedentary work. This diet calls for approximately 2700 calories, supplies a sufficient amount of bulk, is adequate in vitamin content, and provides an adequate protein intake, and a normal fluid content:

The second requirement is that the individual be free from disease in any of his organs. In order to determine this fact, a minimum requirement is a complete history, and a physical examination, in which the minimum laboratory procedures include a urine analysis, hemoglobin determination, a gastric analysis, a stool examination for ova and parasites, and a complete gastro-intestinal x-ray examination in-

SPECIMEN DIET FOR AN AVERAGE MALE DOING SEDENTARY WORK

BREAKFAST

	Total Grams	Carb.	Prot.	Fat
1 Glass Water				
White Bread, 3 slices, 3½" x 4" x ½"	90	48	9	..
Orange Juice, 1 cup	200	20	..	..
Eggs—2 medium-sized	120	..	12	12
Bacon, Crisp, 5 slices 2" x 3" x ⅛"	20	..	8	10
Butter, 2 squares, 1¼" x 1¼" x ⅓"	14	..	..	12
Coffee, 1 cup				
Sugar, 2 teaspoonsful	8	7	..	..
Cream—light, 2 tablespoonsful	25	1.2	.7	4.7
Total	477	76.2	29.7	38.7

LUNCH

	Total Grams	Carb.	Prot.	Fat
1 Glass Water				
Celery, 1 heart, 3 stalks	100	3	1	..
White Bread, 3 slices	100	48	9	..
Lamb Chops, 2	100	..	20	20
String Beans, ½ cup	100	3	1	..
Asparagus, 5 stalks	100	3	1	..
Potato—White, medium-sized	100	18	2	..
Butter, 2 squares	14	..	..	12
Ice Cream	100	20	4	13
Apple, 1 medium-sized	100	13	..	1
Milk, 1 glass, 6 oz.	180	9	5.5	7
Total	994	117	43.5	53

DINNER

	Total Grams	Carb.	Prot.	Fat
1 Glass Water				
Whole Wheat Bread, 3 slices	100	46	10	1
Tomato Juice, 1 cup	200	8	2	..
Celery, 1 heart—3 stalks	100	3	1	..
Chicken, 2 slices, 4" x 3" x ½"	150	..	30	3
Carrots, 1 cup	200	12	2	..
Beets, ½ cup	100	6	2	..
Potato, 1 medium-sized	100	18	2	..
Tomato Salad	100	4	1	..
Banana, 1 large	200	41	2	2
Butter, 2 squares	14	..	..	12
Tea or Coffee				
Sugar, 2 teaspoonsful	8	7	..	..
Cream—Light, 2 tablespoonsful	25	1.2	.7	4.7
Total	1297	146.2	52.7	22.7
Total for Day	2768	339.4	125.9	114.4
Total Caloric Intake—2776				

cluding a gall-bladder function test. A proctoscopic and sigmoidoscopic examination should also be included in the physical examination.

The third requirement is that mental anxiety and fears be allayed through mutual coöperation between physician and patient on the basis

of a thorough understanding of all the factors involved.

The fourth requirement is that the individual coöperate in achieving a balanced life, proportioned between work, recreation, exercise, and rest.

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EXPERIENCES IN DIAGNOSIS WITH THE PERITONEOSCOPE: INDICATIONS FOR ITS USE

By C. ABBOTT BELING, M.D., Med. Sc. D., Newark, N. J.

Read before the Section on Gastro-enterology of the Annual Meeting of The Medical Society of New Jersey
in Atlantic City, June 8, 1939.

Examination of the abdominal cavity through a telescope has been performed for many years on isolated cases by a few investigators. A few years ago, Ruddock re-designed the instrument and used the procedure frequently. As a result of the experience of several surgeons during recent years, we are now in a position to say that peritoneoscopy is a procedure of value.

The peritoneoscope consists of a telescopic lens system, with obliquely forward vision, and a special forceps for taking biopsies under direct vision, both of which may be inserted through an insulated sheath into the abdominal cavity. It causes little or no discomfort; may be carried out under local anesthesia; does not result in prolonged hospitalization; is safe, having a negligible mortality; and allows inspection under direct vision, and the securing of biopsies.

The danger in the use of instruments of this type is over-enthusiasm, and lack of clear knowledge of the indications and contra-indications for their use. It is well, therefore, that we enumerate these before discussing what can be done with the instrument.

INDICATIONS

1. Non-inflammatory diseases of the organs within the greater sac of the peritoneal cavity, excluding the pancreas, kidneys, and other retroperitoneal structures, and the contents and borders of the lesser peritoneal sac.
2. Old chronic inflammatory diseases of the pelvic organs.
3. Suspected neoplasms of the pelvic organs.
4. Suspected ectopic pregnancy.
5. Splenomegaly.
6. All cases of ascites not of cardiac origin.
7. Tubercular peritonitis.

CONTRAINDICATIONS

1. All acute inflammatory diseases of the abdominal cavity.
2. Pneumonia.
3. Stab wounds and bullet wounds of the abdomen.
4. Cases with intestinal obstruction or distension of either the small or the large intestine.
5. Acute perforations of any viscus.
6. Heart failure and advanced cardiac decompensation in the absence of ascites.
7. Advanced pulmonary tuberculosis of both lungs.
8. Extensive operative scars and adhesions thereto.

The contra-indications must be frequently and firmly stressed lest an accident, such as perforation of the bowel, or sudden death, or the spread of an infection causing generalized peritonitis, be blamed on the instrument rather than on the faulty judgment of the operator. In our experience, one may be called upon to perform peritoneoscopy on cases for which it is not indicated.

What can peritoneoscopy do for the general practitioner, or specialist?

CARCINOMA

Exploratory laparotomy is often performed on patients with carcinoma of the stomach or colon with the hope that the growth will be resectable, and the liver free from metastases. Too often the metastases are found, and the abdomen is closed without further surgery. A prolonged convalescence, and a shortening of the duration of life are the usual outcomes. It is in these cases that the greatest service may be rendered. The close coöperation between clinical and laboratory investigation, gastroscopy, roentgen examination, and peri-

toneoscopy will almost invariably determine the extent of the growth, the probability of successful resection, and the presence of metastases.

Following peritoneoscopy under local anesthesia, the patient remains in bed for twenty-four hours, and suffers none of the effects of general anesthesia and manipulation of the abdominal cavity incident to exploration. Prolonged hospitalization and convalescence therefore cease to be a problem, and are reserved rightfully for those cases which are found to be suitable for surgical relief.

All patients with ascites usually require abdominal paracentesis. There is no added discomfort to the insertion of a peritoneoscope at the same time, and much information may often be gained thereby to the patient's advantage. Suspected cirrhosis of the liver may be proven to be papillary ovarian cystadenoma, or even echinococcus cyst. In cases considered hopeless, a thorough inspection of the abdominal cavity has sometimes disclosed conditions which could be relieved. It is particularly important to examine all cases of suspected papillary ovarian cystadenoma, for some of them which have been considered inoperable may be removable and have practically no metastases to other parts of the abdomen.

The diagnosis of tuberculous peritonitis can be positively made by peritoneoscopy with biopsy, and the introduction of air into the peritoneal cavity often brings about prompt improvement. This is certainly less shocking than exploratory laparotomy.

Obscure masses in the pelvis, without a history of recent inflammation may be identified grossly under direct vision, and microscopically from a biopsy. It has also been possible to decide definitely whether a mass was intra- or extra-peritoneal, and to have the accuracy of the observation confirmed on the operating table.

The operative lysis of post-operative adhesions is often studiously avoided by the surgeon in the absence of any definite signs of partial intestinal obstruction, and the inspection of such adhesions with the peritoneoscope greatly enhances the probability of an accurate, intelligent decision.

A few cases of accidental perforation of the bowel have been reported, but it is our opinion that perforation need rarely occur if the puncture site is chosen with due care. Should such an accident take place, it is because the bowel is firmly attached to the parietal peritoneum, and is not mobile. It is, therefore, a simple matter to effect closure of the wound without any soiling of the peritoneal cavity.

None of the cases reported died or became infected. We have not observed any herniation through the wounds, although one case of inoperable papillary ovarian cystadenoma did develop a peritoneal metastasis at the puncture site. No cases of peritonitis have been reported, and we have not personally observed any febrile reaction following the procedure. Patients stand inflation of the abdominal cavity with air without undue discomfort and without pain, unless adhesions to the parietal peritoneum are stretched. As most of the air is removed before the trochar is withdrawn, the patients are able to sit up within twenty-four hours or sooner, without any referred pain to the shoulder. In fact, the majority of our patients have not complained of shoulder pain, although they sat up in bed and ate their meals within eight hours after the completion of the examination. The follow-up reports of several cases of carcinoma of the stomach with metastases to the liver have not indicated any hastening of the final outcome.

The following abstracted case reports are illustrative of the value of peritoneoscopy.

CASE 1

E. F., white male, fifty years of age, with a history of loss of weight and appetite, increasing pallor, reduction in amount of food tolerated, and occasional vomiting.

Examination revealed a movable, firm mass in the epigastrium, which was not tender. Roentgen examination showed a growth involving the pylorus on both curvatures. Gastroscopic examination confirmed the findings, and demonstrated a circumscribed adenoid growth involving the stomach at the upper end of the pyloric antrum on both walls. Above the growth the mucous membrane of the stomach was normal in appearance.

The possibility of gastric resection was seriously considered, but it was decided to submit the patient to peritoneoscopy. Multiple metastases were found over both lobes of the liver. Operation neither advised nor performed. No prolonged hospitalization.

CASE 2

M. M., white female, thirty-four years of age. Had an appendectomy for acute appendicitis with perforation in 1935. Since then she has suffered from spells during which she claims to lose contact with her environment for three to five minutes. They are preceded by pulling sensations at the site of the abdominal scar. She claims that eructation or a drink of water will prevent the attacks.

Observation during attacks did not reveal any suggestion of petit or grand mal. Neurological examination was normal. The patient was highly suggestible.

Because of sensations referable to the previous scar, adhesions were considered to be present, and lysis was to be performed. Peritoneoscopy revealed extensive adhesions of varying density in the right pelvis and the right lower quadrant. Two loops of small intestine were attached to the parietal peritoneum at the site of drainage. Other loops were adherent to each other by many band-like adhesions which also bound them in the pelvis. Cure by lysis was considered improbable. Operation was not performed.

CASE 3

M. B., white female, fifty-eight years of age, with a history of moderate jaundice, loss of appetite, and gradual enlargement of the abdomen.

On examination her skin had an icteric tinge, and her abdomen contained fluid. The jaundice suggested carcinoma of the head of the pancreas, and exploratory laparotomy was considered. Peritoneoscopy revealed diffuse nodular cirrhosis of the liver, with no enlargement of the gall-bladder or other evidences of cancer. No operation was performed.

CASE 4

Miss M., Negro female, twenty-five years of age, with a history of moderate enlargement of the abdomen and loss of weight during the past six months. On examination, the abdomen was moderately enlarged, of doughy consistency, and contained fluid. No masses were felt. The lungs were clear. Tentative diagnosis of the tuberculous peritonitis was made.

Peritoneoscopy demonstrated the presence of slightly cloudy yellow fluid, and numerous tubercles on the small bowel and peritoneum. The abdomen was inflated with air and on the following day her temperature dropped from 100° F. to normal and remained there. The usual exploratory laparotomy was therefore not performed.

CASE 5

E. U., white female, fifty-two years of age, with progressive enlargement of the abdomen during

the past year and pains in the lower abdomen during the past three months. Examination revealed an abdomen tense and round with fluid and a large mass in both fornices of the pelvis. The growth was considered inoperable.

Peritoneoscopy was requested. Two gallons of clear yellow fluid were removed. There was a large, luxuriant, soft, yellowish-white, papillomatous growth, almost filling the entire pelvis, and appearing somewhat like the head of a cauliflower. It obscured the uterus and both ovaries. Several pieces were removed, and on microscopic section proved to be papillary cystadenoma of the ovary. No peritoneal metastases were found.

The growth was considered operable, was subsequently successfully removed, and the peritoneoscopic findings confirmed. Because of the duration of the symptoms, the size of the mass, and the condition of the patient, a diagnosis of carcinoma, probably papillary cystadenoma of the ovary, was made.

Just as the thoracoscope, the cystoscope, and the bronchoscope have become operating instruments, so may we expect to be able to perform procedures such as lysis of adhesions, securing of larger biopsies, and possibly ligation of the Fallopian tubes. We have personally been working on a new instrument to enable the operator to take Kodachrome pictures during each examination, as a permanent record in full color of intraabdominal pathology.

SUMMARY

Peritoneoscopy is a procedure of value because it causes little or no discomfort; may be carried out under local anesthesia, does not result in prolonged hospitalization; is safe, having a negligible mortality; and allows inspection under direct vision, and the securing of biopsies. A thorough knowledge of the indications and contra-indications are necessary before attempting the procedure. The use of peritoneoscopy in various types of conditions is discussed, and several illustrative cases are recited in brief. Further improvement in the instrument, and the permanent recordings of gross pathology in color, are desired and may be expected in the near future.

CORD LESIONS IN PERNICIOUS ANAEMIA

By AMBROSE F. DOWD, M.D., Newark, N. J.

Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey,
June 8, 1939.

Subacute combined cord degeneration is a disease process associated with pernicious anaemia. It usually produces degenerative changes, quite typical histologically and pathologically, in several spinal tracts. The histopathological changes, to which reference was just made, are found almost exclusively in pernicious anaemia, and occasionally in *Bothriocephalus latus* infection. The approximate clinical syndrome which results from this pathology is not pathognomic of pernicious anaemia. It occurs in a number of conditions. Lietheim first wrote of subacute combined cord degeneration in 1887. Later in this country, Putnam and Dana described it in a number of manuscripts, and for many years it was known as Putnam and Dana's disease. More recently it has been the subject of intense and prolonged research, and a vast amount of the appertaining material has appeared in the literature. It has had and has today a variety of unsatisfactory synonyms.

PATHOLOGY

The essential cord pathology is that of softening of the cord throughout cross sections. The foci of destruction first involve the tissues adjacent to the intraspinal arterioles. These perivascular degenerative areas coalesce, extend, and include in their destructive processes cells of the glia—the supportive cells and fibers—and also the nerve fibres and tracts. The fact is that the nerve fibre in its entirety is destroyed. Axones and myelin sheaths appear to degenerate simultaneously. The lipoid materials thus liberated are engulfed by the phagocytic cells, and cystic areas appear. Some secondary and inflammatory changes then occur. A slight gliosis is not uncommon, but there is no progressive proliferation. This slight gliosis probably results because the hypothetical toxin, presumably responsible for the cord degeneration, is of sufficient strength to involve the glia cells, which ordinarily resist

such processes. This, according to most competent observers, differentiates cord degeneration of pernicious anaemia from all other cachectic states. As a result of all this, spongy-like formations containing lipoid materials occur throughout the affected areas. Little scar formation results.

The cord tracts most seriously damaged are the pyramidals and the tracts of Goll, Burdach, and Clarke. However, other tracts are not free from invasion. The spinocerebellar tract, the corticospinal tract, the rubrospinal tract, and the rubroreticular tract are not infrequently invaded.

The pathology first appears in the mid-dorsal cord. Despite the fact that this paper encompasses only the cord in pernicious anaemia, may I remind you that pathological changes occur in the cerebrum, the cerebellum, the pons medulla, the peripheral nerves, and the sympathetic ganglia. From time to time the cerebral nerves are also involved, and an occasional optic atrophy is seen.

CLINICAL SYMPTOMS

The clinical syndrome may be divided generally into:

1. That referable to the posterior columns.
2. That resulting from pyramidal tract invasion.

Dysesthesias are frequently the first symptoms to be noticed in cord degeneration. They consist of a tingling and numbness, which suggest, but by no means establish, central nervous system pathology. They frequently result from circulatory changes, nerve root and nerve trunk changes, and sympathetic pathology. When of cord origin they are not ordinarily accompanied by excessive sensitiveness or sensibility to pain. This is not the invariable rule, however, for increased pain sense is seen now and then. In addition thereto girdle sensations, lancinating pains and gastric and other abdominal crises are not infrequent.

Losses of power to receive stimulations within the tissues occur, and the extremities, because of these losses, are manipulated clumsily. Pain and temperature sense changes are frequent. The individual loses a sense of awareness of the exact position of his extremities. His ability to coördinate diminishes; he frequently walks on a wide base; he sways laterally; and he develops a dynamic ataxia and positive Romberg.

Hypesthesia is the general rule. The deep reflexes are diminished and sometimes disappear. When pyramidal involvement occurs, there follows ordinarily an exaggeration of all the deep reflexes. Positive Babinskis, ankle Clonuses, Oppenheims, Mendels and hyper-tonicity occur. The abdominal and cremasteric reflexes are frequently lost. A spastic paraplegia sometimes exists. Bladder and rectal symptoms are common. Impotence frequently occurs. Stocking and glove hypalgesia and hypesthesia are frequently found. Any combination of pyramidal and posterior column findings may coexist.

The course is variable. At times it progresses rapidly and destructively; at others slowly and accompanied by remissive phenomena. The duration is conjectural; it usually extends over a period of five or more years. The cord syndrome may accompany, precede, or follow the anaemia. In my experience the cord syndrome frequently antedated the appearance of the anaemia, clinically and hematologically. The usual time of the onset is between the fourth and fifth decades. The frequency of the cord syndrome is debatable. Various observers have placed it at 90 per cent, and others at approximately five per cent. In my opinion it approximates 40 per cent.

From a diagnostic standpoint, subacute combined cord degeneration must be differentiated from tabes dorsalis, multiple sclerosis, cord neoplasms, cerebro-spinal lues, leukaemia, Hodgkin's disease, avitaminosis, Friedreich's ataxia and chemical intoxications. The differential diagnosis can ordinarily be made if the patient is carefully examined neurologically, and an abundant and accurate history is secured and considered thoroughly. The laboratory is of inestimable value and assistance.

Frequent blood counts should be secured. Wassermann, Kahn's and Klein's reactions should be had. Colloidal gold curves are frequently helpful. In some instances myelograms and x-rays of the vertebral bodies are beneficial. There should be frequent spinal fluid cell counts. I do not believe that all of these procedures are necessary in any one case, but in a series of cases all of them are found to be indispensable. They must be utilized intelligently.

The treatment of the cord syndrome is at the moment highly controversial. Acrimonious and explosive debates are frequently precipitated by any reference to liver therapy in connection therewith.

LIVER THERAPY

Neuropathic disabilities in pernicious anaemia are by no means hopeless, and in my opinion do not justify pessimism. Nerve root and nerve trunk symptoms and pathology are promptly relieved by liver therapy. The cord pathology, described herein, with the syndrome resulting therefrom, is quite another matter. I do not believe that liver therapy, despite its alleged specificity, can repair a badly and extensively damaged cord. Considerable research, under the most favorable conditions, has clearly indicated that very little repair takes place. However, it is undoubtedly true that under adequate liver therapy the patient suffering from apparent cord damage improves. Under liver therapy a number of patients secure substantial restoration of physiological function, and they recover sufficiently to resume their social, economic, and industrial activities. I am convinced that liver therapy administered intelligently, intensively, and unremittently over long periods arrests the progress of the disease, prevents further damage from cord pathology, and restores the individual so afflicted to a very substantial degree of general effectiveness. By that I mean that the symptoms and the signs of subacute combined cord degeneration lessen materially, and the disability resulting from the illness diminishes concomitantly.

Adequate therapy, in my experience, consists of, in the average case, approximately

two years of intensive liver therapy, orally and parenterally. Occasionally treatment is necessary for a period of three years. The parenteral treatment with potent extracts is preferable. Under such therapy paraesthesias in a large number of cases disappear, the gait improves, the spasticity lessens and the results heretofore mentioned take place. It is impossible to generalize about the amount of liver necessary in a given case. It suffices to say that massive doses, perorally and intramuscularly, are usually necessary. It is important throughout treatment to maintain the red cell count at approximately five million cells. The maintenance of that count is the criterion of the adequacy of therapy. It is of course of transcendental importance to institute a maximum of therapy early. Occasionally it may be necessary to administer liver intravenously.

I heretofore mentioned that liver has a specific effect upon the spinal cord. I think that it is only fair to incorporate herein that there are substantial facts to support the contention. In connection with therapy, I would be remiss if I did not mention the beliefs of a number of physicians that massive doses of iron, particularly in the form of Bland's pills, appear to be very beneficial; they recommend the use of one hundred fifty or more grains a day. I have had no satisfactory experience with that form of therapy.

Ungley has earnestly and enthusiastically recommended that subacute combined cord degeneration be treated by an ox brain diet. He used, whenever possible, the brains of freshly killed oxen; at times frozen brains were used. A number of his cases are said to have improved materially and, strikingly enough, improved promptly; a number, it is said, com-

pletely recovered. The appertaining literature, however, is not at all convincing, and it is frequently admitted that the ox brain diet is of low potency so far as blood regenerative changes are concerned.

Transfusions, in my experience, produced little if any change in the neurological picture of pernicious anaemia. Dilute hydrochloric acid is of course given. Ventriculin is sometimes usefully employed.

If you are to succeed in the treatment of these patients, you must not treat them as a group. You must individualize. Occasionally under liver therapy the disease process, herein described, appears to advance with unusual rapidity and destructiveness. This unfortunate result is so infrequent that we need not be apprehensive about it. The beneficial results, upon a percentage basis, more than justify intensive therapy protractedly. Conspicuously beneficial results ordinarily accrue.

It is my opinion that we can now definitely say that patients suffering from spinal cord, nerve root, nerve trunk, sympathetic ganglia and pathways pathology, in connection with pernicious anaemia, can be greatly benefited by the treatment discussed herein.

May I digress in closing to remind you that many psychiatric disturbances occur during the course of pernicious anaemia. These are disturbances which are frequently intense, and all too often disabling. I have repeatedly seen deliriums, paranoid states, and on a few occasions a typical Korsakoff's syndrome associated with pernicious anaemia. Personality defects are frequently found in connection therewith. I mention them in passing. Time does not permit a detailed explanation.

THE FIRST STAGE OF LABOR

MATERNAL WELFARE ARTICLE NUMBER FORTY-ONE

By ARTHUR W. BINGHAM, M.D., F.A.C.S., East Orange, N. J.

The second of a series of five papers read before the Section on Obstetrics and Gynecology of the Academy of Medicine of Northern New Jersey, March 2, 1939. The first one of the series was that by Dr. J. F. Norton, on page 554 of the September Journal.

The management of the first stage of labor requires judgment and patience, for many times the outcome of the case can here be simplified or complicated, depending on how the first stage is handled.

If good prenatal care has been given, the physician will know at the beginning of labor whether the head is engaged in the pelvis or whether it is at the brim, whether the patient is in good condition or whether she is somewhat toxic.

A patient in labor should be seen by her physician as soon as labor is well established. It is not good obstetrics to order an analgesic and have the nurse call again when the head is on the perineum.

An abdominal examination should be made, and the foetal heart examined. If the patient has had a vaginal examination recently, it will not be necessary to make one at once unless labor is progressing actively.

It does no good to listen to the foetal heart frequently during the first stage. In fact, it may even be harmful for if it is found to be unusually slow, or rapid, or irregular, there may be a tendency to hasten labor or do a cesarean unnecessarily. The failure of the foetal heart in the first stage is a rare occurrence.

If the patient is a primigravida, or a multigravida just starting labor, she should walk about for a little while before the pains become hard. Patients nowadays too frequently go to bed and remain there throughout their labor. The general use of analgesics is probably partly responsible for this.

One rule is imperative. Nothing should be done to hurry the first stage of labor except in the rarest emergency. How many normal cases have been made complicated by hurrying the first stage! We have all seen them.

ANALGESICS

Regarding analgesics—some favor, others criticize their use. Properly used, I believe

they are a great help. Before using one, a vaginal or rectal examination should be made. Which should it be?

If the patient is to be examined by several physicians (consultants, interns, or students), rectal examinations are safer. In the average case, unless the physician is very experienced in rectal examinations, a much more accurate diagnosis can be made by a vaginal examination. Many claim, if properly done, it is just as safe; and I am inclined to agree with them. Before one is done, the patient must be prepared for labor, and nothing must be touched by the examining finger (wearing a sterile glove) until the vagina is reached. The custom of examining the patient in her home to determine whether she is in labor before she goes to the hospital is a dangerous one and should be discontinued. I believe it to be the cause of a number of infections. It is not at all necessary.

One rule is recognized by all obstetricians: Make as few vaginal or rectal examinations as possible during the first stage, but make enough to be sure labor is progressing normally.

What analgesic to use and how much will depend on the patient, and the condition of the cervix. If patient is a primigravida with a cervix not over two fingers dilated and yet having hard pains, there is nothing better than morphine sulphate gr. $\frac{1}{4}$, with hyoscine gr. $\frac{1}{200}$. When this wears off, four and a half or six grains of pentobarbital with, or without hyoscine gr. $\frac{1}{200}$, may be given. The pentobarbital may be repeated every hour or two in one and a half grain doses if the patient is not relieved. The maximum dose should not be given to every patient. A small, delicate patient should not receive the same dose as a larger, more robust patient. Great caution should be used with analgesic in premature labors. Premature babies are much more sensitive to these drugs than full-time babies.

In multigravida the morphine is usually omitted, as delivery may take place inside

three or four hours and cause an asphyxiated baby. In these cases pentobarbital takes the place of morphine; and if delivery is expected soon, it may be well to omit the hyoscine.

Different obstetricians prefer different analgesics. The discussion will bring this out. Some prefer giving a smaller dose of morphine gr. $\frac{1}{8}$, with hyoscine, gr. $\frac{1}{200}$, and pentobarbital. Others prefer ether oil, sodium anytol, paraldehyde, sodium allurate, seconal, etc. Having had very little experience with some of these analgesics, I shall not attempt to discuss their advantages and disadvantages. It is better to stick to one or two methods and so become familiar with their actions on different patients.

The patients must be watched carefully whatever is given, or accidents will occur. It is wise to use side bars on the bed during labor and after labor even though the patient is watched by a nurse.

RUPTURING THE MEMBRANES

I believe if the membranes are intact, with the cervix partially dilated, it is better to leave them alone until the cervix is fully dilated. There is an exception. When the head rests against the membranes and the cervix is about half dilated, a delay in labor will sometimes occur, and the cervix will fail to dilate until the membranes are ruptured artificially, when labor will proceed and the cervix will dilate quite easily. In these cases it is sometimes difficult to puncture the membranes as they are so close to the head.

Be sure that everything used for the case is sterile. Use all precautions against sepsis.

There is too much preventable sepsis. Don't fail to wear a mask when examining a patient at home or in the hospital. The value of mercurochrome instillation is still in doubt.

Be sure an enema is given every twelve hours, and that the bladder does not become distended.

Don't decide it is time for labor to come on, and try to start it up with castor oil and quinine, or pituitary extract, except in very exceptional cases. Especially is this to be avoided in primigravida. It makes the labor harder, and often causes complications.

So-called overtime cases require judgment. Rarely is it necessary to induce labor because the patient has passed the expected time, unless there is some good reason on account of the patient's health.

Don't urge the patient to bear down in the early stages of labor, for she will get tired out before the time comes for this work.

Don't hesitate to examine the patient under an anesthetic if you are unable to diagnose conditions.

Especially in breech presentations is it important not to interfere until the cervix is fully dilated. In making a vaginal examination great care must be taken not to rupture the membranes, or dislodge a foot and so precipitate a delivery before the cervix is dilated, resulting in a stillbirth.

The scope of this paper does not allow me to discuss the first stage in every possible complication. One's best judgment is needed in each case; and when in doubt as to what to do, remember the old slogan, "Keep the Normal Case Normal".

144 Harrison Street

A LESSON FROM A DEATH CERTIFICATE NUMBER THIRTEEN

Patient developed inertia after thirty hours' labor, four fingers dilated. Version performed. Live baby delivered. Severe hemorrhage followed. Patient died in spite of treatment.

Probably a ruptured cervix, quite common in versions with cervix not quite dilated.

Certificate signed by intern: Acute anemia and heart failure.

A. W. BINGHAM, M.D., East Orange, N. J.,

Chairman, Maternal Welfare Committee.

STATE SOCIETY ACTIVITIES

MEDICAL DEGREES

AN HISTORICAL EDITORIAL

The title Doctor was recognized by the founders of The Medical Society of New Jersey at their organization meeting on July 23, 1766. It is curious to note that the first name mentioned at the organization meeting was "The Rev. Mr. McKean", who was chosen President. But in the next paragraph the list of those present began with Rev. Dr. McKean, and the name of each of the other sixteen members present was preceded by the title Dr.

At the second meeting held on November 4, 1766, four persons were proposed for membership,—“Rev. Mr. Brown, Mr. Brown Junior, Doctor Nathaniel Scudder, and Doctor Thomas Henderson”. But in later meetings both the Browns were called doctors. At subsequent meetings Dr. McKean and all others present were recorded as Doctors, although frequently only their last names were recorded, with the whole list preceded by the word “Doctors”.

DELEGATES

For fifty years The Medical Society of New Jersey was the only medical organization of a permanent and authoritative character in New Jersey. It had no connection or official relationship with any society above it or subsidiary to it, or with any medical school or teaching faculty that granted a medical degree. The beginning of a remedy for these defects was contained in a law, passed on February 15, 1816, authorizing the members of the State Society residing in any county, to form a county medical society whose members should be subject to all the rules and regulations of the parent State Society.

Almost exactly two years later an amendment to the 1816 law was adopted, providing that the State Society should consist of *delegates* elected by each county society,—each county society being entitled to four. To be a delegate was a distinction and honor that was conferred on only the more progressive and successful doctors in each county society.

FELLOWS

The first section of a law that was passed on November 24, 1825, provided that all past presidents of The Medical Society of New

Jersey “shall rank as *Fellows*, and be entitled to all the rights and privileges, for life, of delegated members”. To be a Fellow was tangible evidence of honorable service in a responsible position, and is a distinction which is now held by thirteen living members of the State Society.

DEGREE, BACHELOR OF MEDICINE

Very few of the practitioners during the first seven or eight decades of the Society were graduates of medical schools, and it would seem that the degree of M.D. was not usually conferred on the graduates. In the Transactions of 1868, page 20, is the following historical note:

Prof. H. C. Cameron exhibited the diploma of Dr. John Archer, A.M., M.B., a graduate of Nassau Hall (Princeton) in 1760. The Professor stated that this was the first medical diploma conferred in this country. It was given by the old Philadelphia Medical College in 1768, and was signed, among others, by Dr. Wm. Shippen, also a graduate of Nassau Hall. It was remarkable as being the degree of Bachelor of Medicine, instead of Doctor of Medicine, as is now customary. The A.B. 1760, and the A.M. diplomas of Dr. Archer were also shown.

The minutes of the Society do not seem to contain any other reference to the degree of Bachelor of Medicine.

DEGREE, M.D.

At the regular meeting of the State Society held on May 12, 1818, the desirability of conferring the degree M.D. was expressed in the following resolution:

Resolved, That Doctors Lewis Dunham, H. Van Derveer, and A. R. Taylor be appointed a committee to devise some method by which the degree of *Medicinae Doctor* may be conferred on such gentlemen of the faculty of New Jersey as may be deemed worthy, and report at the next semi-annual meeting.

(Note the use of the word *Faculty* to designate the members of The Medical Society of New Jersey, as had been done in the minutes of the meeting of May 1, 1770. Today the official name of the Medical Society of the State of Maryland is “The Medical and Chirurgical Faculty of Maryland”.)

On November 10, 1818, the committee reported progress; and on May 11, 1819, it reported as follows:

The Committee appointed to make application to the College of New Jersey (Princeton), relative to the conferring medical degrees, reported that the Trustees of that institution did not think it expedient at this time.

Since the degree M.D. was seldom conferred by an educational institution, the committee decided to apply to the Legislature for authority for the Medical Society itself to confer the degree, with the result that the law of November 24, 1825, was enacted. The second paragraph of this law reads:

And be it enacted, that The Medical Society of New Jersey (including both Fellows and Delegates) are hereby authorized to institute regulations, which shall again be approved by a majority of the whole number of Fellows acting separately, according to which regulations the said Medical Society of New Jersey may confer the degree of Doctor of Medicine.

On May 9, 1826, The Medical Society of New Jersey took steps to confer the degree of Doctor of Medicine, as is shown by the following entry in the first book of Transactions, page 234:

Dr. C. Smith, from Committee on Regulations for Conferring Degrees, reported the following system:

In conformity with an act, entitled a further supplement to an act, entitled "An act to incorporate the Medical Society of New Jersey," passed 24th Nov. 1825, the said Society institute and ordain the following rules and regulations, for conferring the degree of Doctor of Medicine, authorized by said act:

First. The applicant for the degree of M.D. shall be a member of the medical society of the county where he shall reside, and shall have practised physic for seven successive years with reputation, within the State of New Jersey.

Second. The applicant shall produce satisfactory testimonials of moral character.

Third. The applicant shall read before the Society a dissertation on some medical or philosophical subject; and, if after a competent examination before the Society, by a committee appointed for that purpose, he shall be approved, they shall recommend him to the Society for a degree.

Fourth. The applicant shall then be balloted for by the Society, and admitted to a degree, provided he shall receive the approving votes of three-fourths of the members present.

Fifth. The applicant shall then be entitled to receive a diploma, signed by the President and all the fellows present, for which he shall pay \$15, for the use of the Society.

Sixth. The honorary degree of M.D. may be conferred without the above mentioned formalities,

when recommended by the Standing Committee of the Medical Society of New Jersey, and approved by three-fourths of the members present.

Seventh. That all applications for degrees shall be made at some previous meeting of the Society, but the degree only to be conferred at the annual meeting.

Signed, GILBERT S. WOODHULL, President
WM. VAN DEURSEN, Secretary.

The above regulations were considered and adopted by the Society, and ordered to be signed by the President and Secretary.

It was evidently the common expectation that the degree M.D. would be popular, and frequently sought, as is shown by the following entry in the minutes of the meeting of May 9, 1837, page 229:

The Standing Committee (corresponding to the present Board of Trustees) presented a form of diploma for the honorary degree of M.D., which was accepted; and the secretary was instructed to procure a number of lithographed copies for the use of the Society.

As a matter of fact, the minutes of the Society record only eleven instances in which the degree was conferred up to 1856, as follows:

May 10, 1831, Augustus R. Taylor, Somerset County, President of the State Society in 1822, and 1830.

At the same time, Dr. Peter Vanderburgh, Secretary of the Society was nominated for the degree, but declined the honor.

May 1, 1833, Jephtha B. Munn, Chatham, President in 1828.

May 1, 1833, William D. McKissack, Somerset County, President 1826.

May 10, 1836, John W. Craig, Somerset County, President 1829.

May 8, 1838, Samuel Hays, Newark, President 1834.

January 24, 1854, Charles L. Pearson, Trenton.

May 18, 1856, John Bowne, Hunterdon County.

May 18, 1856, Nathan W. Condit, Morris County.

May 18, 1856, J. B. Skillman, New Brunswick, President 1847.

January 22, 1856, John Blane, Hunterdon County, President 1861.

On May 29, 1872, the degree was conferred on William Pierson, Sr., Orange, Secretary thirty-one years, and President 1869. It is probable that a further search will reveal others on whom the honorary degree M.D. was conferred.

Although The Medical Society of New Jersey seldom exercised its power to confer the degree of Doctor of Medicine, its members

were successful in having this provision retained in the charter of 1864, under which the Society now acts.

DEGREE, DOCTOR OF CIVIC MEDICINE

The degree of *Doctor of Civic Medicine* was also considered by the State Medical Society, as is shown by the following comment by Dr. David C. English in his Presidential address before the Society, as recorded in its minutes of the meeting on June 28, 1898, as follows:

The more thorough teaching of state medicine and hygiene in the regular medical colleges is an important advance as was the first step taken in this country to establish the post-graduate degree of Doctor Medicinæ Civitatis, by Rush Medical College, Chicago, in 1895, which was designed to provide thoroughly qualified health officers for our cities. We regret exceedingly that it was discontinued last year because of the lack of applications, but the dean of the college informs me that it may be renewed again, as the demand for more thorough qualification is increasing.

At about the time that the degree of Doctor of Civic Medicine was proposed, the degree of Doctor of Public Health was generally adopted as being a more expressive term for the practice of the prevention of communicable diseases which was then in process of development. However, with the modern development and wide practice of administrative medicine by the medical societies of the counties, the States, and the American Medical Association, the degree of Doctor of Civic Medicine has become more perfectly descriptive of the major part of the work of the officers and committees of The Medical Society of New Jersey, as is revealed in their annual reports and the transactions of the annual meetings of the House of Delegates.

During the year 1936 the project of granting the degree of Doctor of Civic Medicine was discussed with the authorities of Rutgers University, but they hesitated to consider it on the ground that the rules of the University did not permit them to originate a new degree. However, the granting of the degree of Doctor of Civic Medicine by Rush Medical College is a precedent to be considered. The following letter from Dr. Emmet B. Bay, Dean of Rush Medical College, to the Editor, dated August 30, 1939, explains the attitude of that institution toward the degree:

The degree of Doctor of Civic Medicine is not conferred by Rush Medical College. It was apparently never revived after Rush became affiliated with the University of Chicago in 1898.

In response to your question concerning our atti-

tude toward the plans suggested by The Medical Society of New Jersey, I may say that I can see a genuine place for such a degree, and can see that there is a distinction between such a degree and the degree of Doctor of Public Health. However, I am familiar with the fact that charter stipulations are very difficult to change without risking the loss of some valuable items, and second, I should frankly be surprised if any University would consider the granting of a degree on nomination by another body. This, of course, is a personal and not official opinion.

An alternative to the plan that the Degree of Doctor of Civic Medicine be granted by a university is that The Medical Society of New Jersey shall secure the passage of an amendment to its charter of 1864, so that it will have the authority to grant the degree Doctor of Civic Medicine, in place of the degree Doctor of Medicine, which it has had the power to confer since 1825.

The active promotion of this plan for granting the degree of Doctor of Civic Medicine is in line with the policy of The Medical Society of New Jersey to make a tangible recognition of outstanding services of its members in medicine, as was done by the presentation of bronze plaques to four of its members during the meeting of the House of Delegates on June 7, 1939. (Transactions, 1939, p. 17.)

PRECEDENT OF NEW YORK STATE

New York State furnishes a precedent for granting the honorary degree of Doctor of Medicine on the nomination of The Medical Society of the State of New York.

Dr. Jacob Ferris, of Delhi, New York, was a delegate to the Annual Meeting of The Medical Society of New Jersey held in Flemington on May 23, 1871, and was proposed for honorary membership by Dr. Oakley (Transactions, page 25); and on May 29, 1872, he was duly elected.

In 1865, the honorary degree of Doctor of Medicine was conferred on Dr. Jacobs by the Regents of the University of the State of New York on the recommendation of the State Society.

Dr. Jacobs was born in Peekskill, New York, January 10, 1802, and graduated in medicine from the College of Physicians and Surgeons in 1830. He settled in Delhi and practiced medicine there for over forty-five years. He was in great demand as a consulting surgeon and doubtless was often called into New Jersey. His career was so remarkable that it will be subject of a special historical article to be published in this Journal in the near future.

WELFARE COMMITTEE

A meeting of the Welfare Committee of The Medical Society of New Jersey was held at two o'clock, on Sunday, October first, 1939, in the building of the Broad Street Bank, 143 East State Street, Trenton, N. J., in which the Executive Offices are located. About forty members were present.

The meeting was preceded by meetings of its four sub-committees, at which the projects for the year were discussed, and specific plans for carrying them out were developed.

A light luncheon was served at one o'clock in the Executive Offices.

Past President William J. Carrington presided over the Welfare Committee in the absence of the Chairman, Dr. Hilton S. Read, who is convalescing from an operation. The subjects discussed were the reports of the four sub-committees which had met before the luncheon hour.

THE COMMITTEE ON LEGISLATION

Dr. W. J. Burkett, of Pitman, Gloucester County, Vice-Chairman of the Sub-Committee on Legislation, reported on the morning session of the committee.

A. *Unqualified Candidates for Licensure to Practice.* The first item of Dr. Burkett's report was personal bills introduced in the Legislature authorizing the Board of Medical Examiners to admit to the examinations for medical licensure two persons whose educational and preparatory qualifications were not up to the standards required by the Board. Dr. Burkett reported that these bills will be called up for legislative consideration in the very near future, and asked that the Welfare Committee formulate the principles for the guidance of the Committee on Legislation in its attitude toward the bills.

In the proposed legislation some legislators seemed to expect that in return for their support of Assembly Bill 210, heed should be given to their proposal to enact what they consider to be minor exception to the law for which they had voted.

The main point in the discussion was whether or not The Medical Society of New Jersey should yield in any degree to political influence. It was explained that a legislator feels that he should introduce a bill which is demanded by any group of his constituents, but that his action does not necessarily mean that he exert himself to secure its passage.

The committee approved the sending of letters to candidates for election to the Assembly and Senate, and to the members, telling them that the Medical Society, through its

county representatives—the keymen—would be happy to discuss the viewpoint of the Society, and of the public, with regard to bills proposed in the Legislature on medical and health matters.

B. *Legislative Agent.* The Welfare Committee also discussed question of employing a legislative agent, as some State Societies have done. It was felt that there was a legitimate field for a legislative agent, but that it had been found almost impossible to find an experienced layman who would always act according to the time-honored ethics of the Medical Profession.

The consensus of opinion of the members of the Welfare Committee was that it would be desirable to employ a legislative agent provided he is a physician who has demonstrated his insistence on maintaining the high principles of The Medical Society of New Jersey.

2. THE SUB-COMMITTEE ON MEDICAL PRACTICE

Dr. David B. Allman, Chairman of the Sub-Committee on Medical Practice, reported that the committee had discussed the proposition that some of the Federal money allocated for Maternal Welfare and Child Hygiene should be spent on the medical care of patients who are in the indigent class. It was the opinion of the committee that the work which is now being done by the committees with the aid of a Federal grant is outstanding, and that the scope of its activities is essentially educational; and that to divert any of its funds to any other object would seriously interfere with its present system.

This attitude was unanimously approved by the Welfare Committee.

3. SUB-COMMITTEE ON PUBLIC HEALTH

Dr. Stanley Nichols, Chairman of the Sub-Committee on Public Health, reviewed three factors, which will have a dominating influence on the practice of Public Health in New Jersey:

A. The findings of the Governor's Committee will be discussed at the Health and Sanitary Conference of all groups of public health workers to be held on November 17.

B. The Wagner Health Bill will be seriously considered by Congress this Fall and Winter.

C. The Presidential campaign, next Summer, when all the national health problems will be discussed.

The committee therefore advocates the support of two fundamental principles:

a. Education of all groups in order that they shall recognize good medical care.

b. Education of physicians to improve the quality and scope of their services, and to promote health insurance.

Dr. Nichols compared the eleven Advisory Committees on the various phases of public health to a champion football eleven whose accomplishments are recognized as outstanding.

Dr. A. E. Jaffin, Chairman of the Advisory Committee on Tuberculosis, made a brief plea for the participation of family doctors in the testing of groups of school children.

Dr. C. Byron Blaisdell, Chairman of the Advisory Committee on Venereal Diseases, reported that the number of clinics had increased from thirty-eight last year to seventy-four at the present time. He also reported that the prenatal Wassermann examinations are often done too late for effective treat-

ment, and urged physicians to make the examinations earlier in pregnancy.

Dr. Millard F. Sewall, Chairman of the Advisory Committee on Traffic Accidents, urged physicians to coöperate with the State Commissioner of Motor Vehicles in securing data on accidents in which life and health are involved.

4. PUBLIC RELATIONS

Dr. Wilkes reported for Dr. J. H. Kler, Chairman of the Sub-Committee on Public Relations, that the committee will continue its work of public health education all along the lines which have proved successful in previous years.

REFUGEE PHYSICIANS

The problem of accepting refugee physicians as members of county medical societies was briefly discussed, and the adoption of a uniform method of action was urged.

ADVISORY COMMITTEE ON TUBERCULOSIS

A meeting of the Advisory Committee on Tuberculosis was held on July 23rd, 1939, with the Chairman, Dr. A. E. Jaffin, presiding.

The following agenda were announced for the meeting:

- I. Extension of Surveys in High Schools and Other Adolescent Groups.
- II. Plans for Case-Finding in Adult Groups.
 1. X-ray all adults in private practice as a part of periodic health examination.
 2. Urge chest x-ray of all hospital admissions.
 3. Urge fluoroscopic or x-ray examination of all prenatal cases.
 4. Urge x-ray examination of all adult groups, especially as encountered in the various industries, custodial institutions, police and fire departments, school personnel, transportation employees, food-handlers, waiters, domestics, WPA workers, recipients of public relief, and all groups in the lower economic levels.
- III. Urge Post-Graduate Courses in the Modern Concepts of Tuberculosis and Case-Finding Methods.

I. EXTENSION OF SURVEYS IN HIGH SCHOOLS AND OTHER ADOLESCENT GROUPS

Reports from various parts of the country, and the experience in Hudson County were so convincing as to the value of periodic tuberculosis surveys in the high schools and colleges, that it was obviously the duty of this committee to urge the extension of these efforts throughout the rest of the State. The committee was unanimous in this respect. In the last survey in Hudson County, 62 per cent of the cases of *pulmonary* tuberculosis discovered were in the *minimal* stage.

II. PLANS FOR CASE-FINDING IN ADULT GROUPS

1. The advisability of making an x-ray of the chest of all adults part of the periodic health examination is self-evident. The mere absence of physical signs of pulmonary disease does not exclude its presence. It is well known to all versed in pulmonary diagnosis that one may encounter far-advanced disease without detectable physical signs.

2. As another great step in the elimination of sources of infection in general hospitals affecting nurses and internes particularly, the routine x-ray examination of the chest of all hospital admissions was urged. It is also not an uncommon experience to have cases referred to the clinic or for private consultation, suffering from advanced tuberculosis discov-

ered after a tonsillectomy or some major operation. The possibilities for further prevention in the family contact of such individuals is also very great.

3. The above suggestions apply with equal force to the prenatal x-ray or fluoroscopic examinations of all pregnant women.

4. The fourth item with reference to plans for case-finding in adults met with the greatest amount of discussion and opposition. Several members of the committee were firmly opposed to directing special attention to any particular groups in spite of the obvious advantage of selecting certain bodies of men and women in preference to others. In the first place, in order to cover the greatest amount of ground with a minimum of effort and expense, experience has taught us that work in organized groups is most fruitful. For this purpose it was suggested that surveys be recommended for large adult groups, especially as encountered in the various industries, custodial institutions, police and fire departments, etc. Because of the probability of a still higher incidence that might be encountered in WPA workers and recipients of public relief, as well as in other groups in the lower economic levels, these seemed to be particularly fruitful fields.

The objections previously mentioned were most strenuously raised against WPA workers and recipients of public relief. Further objection was raised because of the possibility that the profession might misunderstand these recommendations, and assume that these surveys were to be done free. Personally, I wish to go on record as definitely opposed to this curtailment of a statement which directs the attention of those who may plan to do this work to the special groups in which the highest incidence of early tuberculosis may be expected. I wish also to emphasize the fact that there is nothing in this suggestion stating how these surveys are to be made or by whom. As a committee we are not responsible for the economics involved, but are primarily and solely interested in early case-finding as a means of preventing and eliminating tuberculosis.

III. URGE POST-GRADUATE COURSES IN THE MODERN CONCEPTS OF TUBERCULOSIS AND CASE FINDING METHODS

There is a great deal of objection throughout many parts of the State against tuberculosis surveys as a Public Health measure. There are many physicians and roentgenologists who sincerely believe that such surveys are inimical to their interests. They would have Mantoux tests and x-raying of reactors paid for at rates that would be prohibitive. Human nature is such that, when an individual feels well, he will not be particularly interested in spending any amount of money on a health examination, unless it be extremely nominal. If we are to wait until he has reason to be anxious about his health, the probabilities are that we will find advanced disease. It has been proved over and over again that, if we offer the public the inducement of a nominal fee, more and more will take advantage of the opportunity. Furthermore, as a result of large group surveys or individual films at nominal cost, a considerable number of people in whom further medical attention is called for will return to their own physician and then gladly submit to further x-rays privately, if necessary.

These facts, as well as the great necessity of making the modern concept of the pathogenesis of tuberculosis better understood by all, call for greater activity on the part of the Committee on Post-Graduate Education in organizing courses in these subjects throughout the State. The members of the profession will then appreciate the difference between private practice and their duty as physicians in coöperating for the prevention and elimination of the white plague by modern public health methods. Moreover, they must also be shown that in doing so, not only will the public at large reap the benefits, but that their own private work will increase along the same lines.

Shortly before the meeting of the committee, there appeared in the *Jersey Journal* a vicious attack on Senator Bowers' Bills 92, 93, and 94 by a local chiropractor. His statement was full of untruths, attacking the tuberculin test. The committee authorized a reply to the paper by the Chairman.

ABRAHAM E. JAFFIN, *Chairman.*

CLINICAL MEETING

THE MEDICAL SOCIETY OF NEW JERSEY

Hosts—Hudson County Medical Society,—James F. Norton, President

Date—November 9th and 10th, 1939

GENERAL COMMITTEE

S. A. Cosgrove, General Chairman
 Frank J. McLoughlin—St. Francis Hospital
 Lucius F. Donohoe—Bayonne Hospital
 Thomas McG. Brennock—Greenville Hospital
 George O'Hanlon—Jersey City Medical Center
 James L. Cobham—Christ Hospital
 Edward G. Waters—Margaret Hague Maternity Hospital
 Berthold S. Pollak—Hudson County Tuberculosis Hospital
 J. Lawrence Evans—North Hudson Hospital
 Ernest H. McDede—West Hudson Hospital
 Louis Pyle—Fairmount Hospital
 Joseph F. Londrigan—St. Mary's Hospital
 William J. Monaghan—Hudson County General Hospital
 R. J. Lynch—Hudson County Hospital for Mental Diseases

COMMITTEE ON PROGRAM

Earl J. Halligan	S. R. Woodruff
T. J. Schuck	L. V. Lindroth
Edgar Burke	Hyman Borshaw
T. J. White	A. J. Conty
Herman Jaffe	Thomas J. Keegan

COMMITTEE ON DINNER

George Ginsberg	C. B. Kelley
N. M. Alter	J. P. Stout
W. M. Doody	W. J. Snyder
Julius Heilbrun	J. A. Murray

COMMITTEE ON TRANSPORTATION

V. J. Sheeran	Charles Sirken
E. J. Chapman	Herman Behrens
J. S. Madaras	W. J. Gleeson
E. M. Kiely	Maurice Shapiro

COMMITTEE ON REGISTRATION AND RECEPTION

Henry Spence	J. I. Berlin
C. M. Bahnson	S. I. Kooperstein
J. N. Connell	P. E. Maras
H. C. Benjamin	R. L. Ballinger

COMMITTEE ON CORRESPONDENCE AND PUBLICITY

H. H. Tyndall	L. L. Perkel
William H. Barbarito	M. T. Long
V. P. Butler	W. L. Williamson
A. E. Jaffin	A. A. Mutter

TENTATIVE PROGRAM

FIRST DAY, NOVEMBER NINTH

9 A. M.

Operative Clinics, case presentations, etc.

General Surgery—

Christ Hospital
 176 Palisade Avenue, Jersey City
 St. Francis Hospital
 25 East Hamilton Place, Jersey City

Bayonne Hospital
 East 30th Street, Bayonne

North Hudson Hospital
 658 Park Avenue, Weehawken

General Medicine—

St. Mary's Hospital
 Willow Avenue, Fourth Street, Hoboken

St. Francis Hospital

Jersey City Medical Center
 Baldwin Avenue, Montgomery Street, Jersey City

Pediatrics—

Christ Hospital
 Margaret Hague Maternity Hospital
 Clifton Place, Jersey City

Industrial and Traumatic Surgery—

North Hudson Hospital
 St. Mary's Hospital
 Jersey City Medical Center

Neuro-Surgery—

Jersey City Medical Center

Bronchoscopy and Chest Surgery—

Hudson County Tuberculosis Hospital
 Clifton Place, Jersey City

Obstetrics—

Margaret Hague Maternity Hospital

Urology—

Bayonne Hospital

Psychiatry—

Hudson County Hospital for Mental Diseases
 County Road, Secaucus

2 P. M.

Dry Clinics; Round Table Conferences at Jersey City Medical Center under the direction of the Staff Members of:

North Hudson Hospital
West Hudson Hospital
Fairmount Hospital

Greenville Hospital
Bayonne Hospital
Margaret Hague Maternity Hospital
Jersey City Medical Center

5:15 P. M.

Business Meeting of the Hudson County Medical Society at the Carteret Club.

SECOND DAY, NOVEMBER TENTH

9 A. M.

Operative Clinics, case presentations, etc.

General Surgery—

St. Mary's Hospital
North Hudson Hospital
Jersey City Medical Center
Greenville Hospital
1825 Hudson Boulevard, Jersey City

General Medicine—

Bayonne Hospital
Christ Hospital
North Hudson Hospital

Pediatrics—

North Hudson Hospital
Margaret Hague Maternity Hospital

Industrial and Traumatic Surgery—

Christ Hospital
St. Francis Hospital

Neuro-Surgery—

Jersey City Medical Center

Bronchoscopy and Chest Surgery—

Hudson County Tuberculosis Hospital

Obstetrics—

Margaret Hague Maternity Hospital

Urology—

Bayonne Hospital

2 P. M.

Dry Clinics; Round Table Discussion at Jersey City Medical Center under the direction of the Staff Members of:

St. Francis Hospital
Christ Hospital
St. Mary's Hospital
Hudson County Tuberculosis Hospital
Hudson County General Hospital
Hudson County Hospital for Mental Diseases

7 P. M.

DINNER at Carteret Club, Boulevard-Duncan Avenue, Jersey City

Toastmaster—James F. Norton

Principal Speaker—Morris Fishbein, M.D., of Chicago, Illinois, Editor Journal American Medical Association.

Requests for additional information may be addressed to Dr. S. A. Cosgrove, General Chairman, Margaret Hague Maternity Hospital, Jersey City, N. J.

SUPPLEMENTARY LIST OF MEMBERS

The following physicians, 251 in number, have qualified as members of The Medical Society of New Jersey, between March 15 and September 30, 1939; and their names are to be added to the Official List, which was issued as a supplement to The Journal of April, 1939:

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

- Agayoff, John D., 127 S. Wash'g'n av., B'rg'n'f'd (2)
 Alexander, Samuel, Main st., Park Ridge (2)
 Alexander, Walter G., 48 Webster pl., Orange (7)
 Allegrante, Anthony J., W'h'g'n Val. rd., M'rtinsv'le (18)
 Allen, Raymond N., 144 Harrison st., E. Orange (7)
 Angelillis, Paul, 76 State st., Hackensack (2)
 Arlitz, Wm. J., 107 Newark st., Hoboken (9)
 Artaserse, Geo. V., 185 Bergen av., Jersey City (9)
 Axilrod, Maurice Harry, 2620 Pacific av., Atl. C'y (1)
 Baldwin, John F., 1474 Windsor rd., W. Eng'w'd (2)
 Bar, Samuel, 54 Main st., Englishtown (13)
 Barbash, R., 835 Red rd., Teaneck (2)
 Barone, Francis A., 12 Audubon av., Jersey City (9)
 Basralian, Jos. B., 238 Blvd., Hasbrouck Hgts. (2)
 Bengelsdorf, Aron, 29 Clinton pl., Newark (7)
 Bernstein, Julius, 345 13th av., Newark (7)
 Bew, Richard C., 1217 Pacific av., Atlantic City (1)
 Beyer, Wm., 612 Undercliff av., Edgewater (2)
 Bickner, Alvah W., 84 Park av., Rutherford (2)
 Black, LeRoy W., 33 W. Passaic av., Rutherford (2)
 Bonomo, Michael J., 587 S. 10th st., Newark (7)
 Brandenburg, Leo W., 4260 Blvd., Union City (9)
 Branon, Mark E., 52 Park av., Rutherford (2)
 Breitstadt, Chas. A., 563 Summer av., Newark (7)
 Brennan, Alfred T. V., Jr., 275 Engle st., Englew'd (2)
 Breslow, Alexander E., 930 Pierpont st., Rahway (20)
 Brock, H. F., 417 W. Broad st., Westfield (20)
 Brodtkin, Louis Andrew, 81 19th av., Newark (7)
 Broselow, Benjamin G., Delsea dr., Franklinville (8)
 Brothers, James H., Jr., 60 Park pl., Newark (7)
 Brown, Edward V., 9 Park av., Caldwell (7)
 Brown, Leonard, 190 Park st., Ridgefield Park (2)
 Bruning, Richard H., 372 Wyoming av., Maplew'd (7)
 Bump, Samuel C., 65 N. Maple av., Ridgewood (2)
 Burbank, Hugh E., 262 Stuyvesant av., Lyndhurst (2)
 Butler, Samuel S., 1100 Kaighn av., Camden (4)
 Calabrese, D. John, 139 Rochelle av., Rochelle P'k (2)
 Campo, Anthony Guy, 200 Broadway, Westville (8)
 Cantini, Raphael S., 147 E. 7th st., Plainfield (20)
 Carlisle, Paul E., 763 Broad st., Newark (7)
 Carr, Alexander, Box 153, Metuchen (12)
 Carroll, Thomas R., 754 Anderson av., Cliffside P'k (2)
 Cartisser, Joseph James, Sergeantsville (10)
 Caruso, Paul Felix, 196 Hackens'k st., Wood Ridge (2)
 Castellano, Martin G., Essex Mt. San., Verona (7)
 Cetrulo, Gerald I., 234 Mt. Prospect av., Newark (7)
 Chernus, Jack, 443 Belmont av., Newark (7)
 Cheskin, Louis J., 115 Mapes av., Newark (7)
 Christensen, O. D., 326 Madison av., Hasbr'k Hts. (2)
 Clock, Ralph O., 20 Ridgecrest W., Scarsdale, N.Y. (2)
 Coburn, J. Wesley, 111 N. Oraton Pky., E. Orange (7)
 Cohn, George M., 748 S. 10th st., Newark (7)
 Conover, Ellsworth E., High Bridge (2)
 Cooper, Jules, Washington st., Woodbine (5)
 Coplin, George J., 510 E. Jersey st., Elizabeth (20)
 Corn, David, 119 Park st., Ridgefield Park (2)
 Coward, Edwin H., Shore rd., Northfield (1)
 Cox, Wm. T. R., 115 Princeton rd., Elizabeth (20)
 Crecca, Anthony D., 76 2nd st., Newark (7)
 Ctibor, Vladimir F., Califon (10)
 D'Amato, Chas. R., 324 Hoboken rd., E. Ruth'rf'd (2)
 D'Ambola, Philip R., 21 S. 6th st., Harrison (7)
 Danzis, Louis, 863 18th av., Irvington (7)
 Darby, Chas. Eugene, Plym'th & At. av., Oc'n C'y (5)
 Daron, Simeon, 31 Lincoln Park, Newark (7)
 Davis, John S., 527 Cooper st., Camden (4)
 Davis, Wm. J., 144 Harrison st., East Orange (7)
 Day, Willis Bronson, 407 E. 7th st., Plainfield (20)
 Dayton, Spencer T., 86 W. Demarest av., Eng'ew'd (2)
 Decker, John G., 216 Blvd., Hasbrouck Hgts. (2)
 Delanty, Katherine, 55 Tonnele av., Jersey City (9)
 Denig, Ralph D., 370 State st., Hackensack (2)
 Diamond, J. George, 512 W. Front st., Plainfield (20)
 DiFino, Felix J., 88 Jefferson st., Newark (7)
 DiMarino, Anthony J., 735 Delaware st., Paulsboro (8)
 Dolsky, Irving, 509 N. Wood av., Linden (20)
 Donnelly, Wm. A., 60 N. Hartford av., Atl. City (1)
 Douglass, Wm. C., 15 Olcott av., Bernardsville (18)
 Duffy, Joseph F., 358 Kinderkamack rd., Westw'd (2)
 Durrah, Fred F., 310 Plainfield av., Plainfield (20)
 Eason, Samuel W., 48 DeForest av., Summit (20)
 Ebenfeld, Samuel W., 344 High st., Newark (7)
 Ehrlich, Max, 379 Elmora av., Elizabeth (20)
 Eisemann, Jerome S., Alloway (17)
 Ellis, Moury I., 177 S. Clinton st., E. Orange (7)
 Epstein, Harry B., 31 Lincoln Park, Newark (7)
 Eulner, Elmer Harold, 216 Henry st., S. Amboy (12)
 Faber, Edward, 154 Bergen av., Jersey City (9)
 Fadden, F. J., Jr., 275 Engle st., Englewood (2)
 Farmer, Vincent, 288 State st., Hackensack (2)
 Fialk, Harry, 996 Hudson av., Union City (9)
 Fiedler, Michael, 247 Crawford ter., Union (20)
 Fink, A. Elston, 489 High st., Newark (7)
 Fisher, Stella C., 4401 Westfield av., Camden (4)
 Fliegel, Wm. M., 85 W. Passaic st., Maywood (2)
 Flower, Morrie Aaron, 39 Lincoln Park, Newark (7)
 Fortunato, Jos. F., 224 Van Buren st., Newark (7)
 Frank, Reuben, Hanover & H'mpt'n sts., Pemb'rtn (3)
 Franklin, Frank A., 304 Central av., Orange (7)
 Frazee, Wm. H., Jr., 513 Main st., Toms River (15)
 Friedrich, A. H., 424 Lafayette st., Newark (7)
 Geller, Samuel, 784 High st., Newark (7)
 Gerard, Patrick D., 364 Roseville av., Newark (7)
 Giannetti, Ernest D., 180 Glen Ridge av., M'tcl'r (7)
 Gilligan, Walter W., 460 Franklin av., Nutley (7)
 Glasser, Benjamin F., 316 George st., N'w Bruns. (12)
 Glazier, Jesse T., 670 Sanford av., Newark (7)
 Gluckman, I. E., 78 Johnson av., Newark (7)

- Gluckman, Saul K., 78 Johnson av. Newark (7)
 Goldberg, Isidore, 303 N. Wash'gt'n av., D'nell'n (12)
 Goldman, Solomon, 43 Paterson st., N'wBr'ns'w'k (12)
 Granberry, D. Webb, 136 S. Main st., Orange (7)
 Greenberg, Max, 29 W. Henry st., Linden (20)
 Greenberg, Solomon, 119 W. 28th st., Bayonne (9)
 Grimes, Jesse R., 214 Washington av., Dumont (2)
 Grimes, Robert R., 455 Queen Anne rd., Teaneck (2)
 Grosfeld, Wm., Valley View San., Paterson (2)
 Hanrahan, J. M., 678 N. Broad st., Elizabeth (20)
 Harman, Byron M., Essex Co. San., Verona (7)
 Harrington, Walter L., 104 S. Munn av., E. Orange (7)
 Harryman, Wm. K., 271 Union st., Hackensack (2)
 Hawke, Edward K., 113 Main st., Newton (19)
 Hayden, Walter G., 504 Main st., Toms River (15)
 Heffner, Geo. P., Bound Br'k Hosp., B'nd Br'k (18)
 Henry, George, Flemington (10)
 Henshaw, George R., 49 Park st., Montclair (7)
 Hensle, Otto S., 5 Pangborn pl., Hackensack (2)
 Hicks, Alfred M., 65 N. Fullerton av., Montclair (7)
 Higi, Joseph E., 529 Park av., Orange (7)
 Hillsman, Robert B., 268 Vandelinda av., Teaneck (2)
 Hofer, Clarence J. M., 463 Main st., Metuchen (12)
 Hofer, Wm. R., 463 Main st., Metuchen (12)
 Holtzman, Michael, 1305 North av., Elizabeth (20)
 Hubach, Maximilian F., Jr., 307 M'tg'm'ry st., Bl'mf'd (7)
 Inge, Hutchins F., 205 S. Orange av., Newark (7)
 Isaac, Benoit C., 94 Oakwood av., Orange (7)
 Jackson, D. P. D., Front st., Belvidere (21)
 Johnston, Julian F., Main st., Chatham (14)
 Katz, Herbert Irving, 278 Park av., Paterson (16)
 Kepler, Carl R., 190 Clinton av., Newark (7)
 Kerns, Francis J., 526 W. Market st., Newark (7)
 Kiefer, Walter E., 232 Blake av., New Brunsw'k (12)
 Kilborn, Melville G., 7 Gilbert pl., W. Orange (7)
 Kingslow, Geo. L., 346 First st., Hackensack (2)
 Klein, Edward F., 136 Market st., Perth Amboy (12)
 Klein, Henry L., Merck & Co., Rahway (20)
 Kleinman, Maurice, 198 Avon av., Newark (7)
 Knapp, Victor, 505 Second av., Asbury Park (13)
 Knox, Chas. A., 138 Bergen av., Ridgefield Park (2)
 Kosminsky, Louis, 30 W. Edsel bldy., Palisades P'k (2)
 Krichbaum, Carroll E., 63 Myrtle av., Montclair (7)
 Kvint, Jos. A., 101 W. 7th st., Plainfield (20)
 Lamberto, Vito A., 422 Stuyvesant av., Lyndhurst (2)
 Lasley, James M., Greystone Park (14)
 Latona, J. A., 78 Main st., Lodi (2)
 LeFavor, Dean H., 619 Morgan av., Palmyra (3)
 Leining, Albert, 1 4th st., Weehawken (9)
 Lemmon, Junius M., 28 W. W'sh'gt'n av., W'h'gt'n (21)
 Lemmerz, Willard H., 184 H'ck'ns'k av., W'dRdg. (2)
 Levine, Edward P., 86 Clinton av., Newark (7)
 Levinson, Robert M., 859 S. 13th st., Newark (7)
 Levitas, Geo. M., 77 Fairview av., Westwood (7)
 Lillen, M. M., 152 Clark st., Hillside (20)
 Linke, James J. P., 245 E. Front st., Plainfield (20)
 Liva, G. Albin, Madison & Franklin avs., Wyckoff (2)
 Liva, Paul F., 280 Stuyvesant av., Lyndhurst (2)
 Lombardi, Frank Louis, 25 E. Clinton av., B'rg'n'f'd (2)
 Lord, C. Donald, 496 S. Maple av., Glen Rock (2)
 Lovejoy, Jas. L., 224 Somerset st., Bound Br'k (18)
 Lovell, John F., 1011 Clinton av., Irvington (7)
 Lyon, Charles H., S. Main st., Phillipsburg (21)
 Maas, Max A., 329 Clinton av., Newark (7)
 Maciejewski, Anthony S., 212 VanBuren st., N'w'k (7)
 Magee, David M. P., 407 Sewall av., Asbury Park (13)
 Magee, Henry Ross, 412 Main st., Hackensack (2)
 Mancene, Edw. M., 145 Marshall av., Little Ferry (2)
 Martin, Wm., Hotel Ambassador, Atlantic City (1)
 Marts, George H., 956 Park av., Plainfield (20)
 Marvel, Philip, Jr., 101 S. Indiana av., Atl. City (1)
 Marx, Frederick J., 486 Churchill rd., W. Englew'd (2)
 Matera, Joseph, 506 Garden st., Hoboken (9)
 Maxwell, Carl A., 117 Grand av., Hackettstown (21)
 McCallion, Wm. H., 722 Westminster av., Elizab'h (20)
 McDede, Ernest H., 319 Ridge rd., Lyndhurst (2)
 McDonnell, Gerald E., 41 Cherry st., Mt. Holly (3)
 McFeely, P. R., 242 Palisades av., Bogota (2)
 Merrill, Chas. F., 16 S. 3rd av., Highland Park (12)
 Messina, Thomas, 75 Chelsea av., Newark (7)
 Messinger, Samuel, 31 Roosevelt av., Carteret (12)
 Miller, Nathan, 861 Lyons av., Irvington (7)
 Minier, Carl L., 25 N. Harrison st., E. Orange (7)
 Miranti, Paul J., 760 West Side av., Jersey City (9)
 Moress, Edward J., 1551 Maple av., Hillside (7)
 Muller, Joseph H., 867 S. 13th st., Newark (7)
 Murphy, Albert T., 1108 Anna st., Elizabeth (20)
 Naidorff, Saul A., 404 W. 7th st., Plainfield (20)
 Nobile, James John, 913 Hudson st., Hoboken (9)
 Orris, Harold J., 1463 Maple av., Hillside (7)
 Ostrowski, S. J., 265 Broad st., Bloomfield (7)
 Pansy, Abraham A., 12 Jackson st., South River (12)
 Parry, Allen A., 46 Green Village rd., Madison (14)
 Pindar, Arthur W., 627 Queen Anne rd., Teaneck (2)
 Pindar, Irene C. D., 627 Queen Anne rd., Teaneck (2)
 Placa, James A., 11 Ethelbert pl., Ridgewood (2)
 Polk, Charles C., 114 E. 7th av., Roselle (20)
 Proctor, Jesse E., 15 N. 13th st., Newark (7)
 Protzman, Thos. B., 39 Park pl., Englewood (2)
 Quin, John A., 1492 Main st., Rahway (20)
 Reilly, David F., Bergen Pines, Oradell (2)
 Remondelli, Raphael E., 282 S. Orange av., New'k (7)
 Roccobono, Cosimo S., 334 Park av., Paterson (16)
 Richards, Ernest W., 374 DeWolf pl., Hackensack (2)
 Riley, H. W., 1 Lincoln pl., E. Rutherford (2)
 Riordan, John, 110 Maple st., Rutherford (2)
 Rizzoli, Luigi, 15 Peck av., Newark (7)
 Robinson, Lindsay E., 332 Park av., Newark (7)
 Rogers, Harry, 144 Harrison st., E. Orange (7)
 Romano, Anthony M., 134 Broadway, Hillside (2)
 Rose, Abraham B., 212 S. Broad st., Elizabeth (20)
 Rose-Parry, Antoinette C., 46 G'nV'lage rd., M'dis'n (14)
 Rosenthal, A., 43 Third av., Atlantic Highlands (13)
 Ross, Selig J., 72 W. Allendale av., Allendale (2)
 Rumage, Wm. T., 513 Sanford av., Newark (7)
 Russomanno, Raphael, 621 Mt. Prospect av., N'w'k (7)
 Sager, Harold, 19 W. 22nd st., Bayonne (9)
 Salsberg, Ralph H., 23 Johnson av., Newark (7)
 Saltus, Lloyd S., Loantaka rd., Morristown (14)
 Samuel, Jerome H., 31 Lincoln Park, Newark (7)
 Santoro, Thomas A., 272 S. 8th st., Newark (7)
 Saporito, Archibald R., 119 Ridge av., N. Arlingt'n (7)
 Schretzmann, Rudolph C., 50 Ridge rd., Rutherford (2)
 Schweizer, Roman Geo., 36 Summit rd., Elizabeth (20)
 Scillieri, John, 142 S. Main st., Hackensack (2)
 Sciorsci, Edward F., 609 Bloomfield st., Hoboken (9)
 Sellitto, A. M., 263 Valley st., So. Orange (7)
 Serri, William S., Main st., Mullica Hill (8)
 Shapiro, Nathaniel J., 192 Palisade av., Union C'y (9)
 Shayevitz, Abraham S., 170 Main st., S. River (12)
 Shlionsky, Herman, Es. Co. M't'l Hy. Cl., Cdr. Gr. (7)

Smith, Edward M., 39 Green Village rd., Madison (14)	Vaccaro, S. P., 509 Fourth av., Asbury Park (13)
Smith, Jos. A., 133 Kearny av., Perth Amboy (12)	Vandersluis, Harold H., 86 S. Main st., Park Ridge (2)
Spalding, Henry J., 512 45th st., Union City (9)	Van Winkle, Chas. I., 79 Ridge rd., Rutherford (2)
Spaldo, John Louis, State Village, Skillman (18)	Vilardo, R., 50 Passaic st., Garfield (2)
Spiegelglass, Abraham B., 417 Main st., H'ck'ns'k (2)	Voss, John C., 634 Thomas av., Riverton (3)
Stimus, Howard G., 300 Kaighn av., Camden (4)	Wallack, Chas. A., 66 Baldwin av., Newark (7)
Stoddard, G. V., 41 S. Munn av., E. Orange (7)	Wayne, David M., 89 Girard pl., Newark (7)
Strauss, Clifton J., 960 Spr'g'd av., New Providence (20)	Wegrocki, Adolph A., 186 Warwick st., Newark (7)
Strauss, Frederick, 777 S. 20th st., Newark (7)	Weissman M. T., 947 E. Jersey st., Elizabeth (20)
Sturchio, Eugenio, 178 Mt. Prospect av., Newark (7)	Welkind, Allen A., 53 Lincoln Park, Newark (7)
Stybel, Joseph, 806 W. Front st., Plainfield (20)	Westney, F. Rolfe, 1920 Pacific av., Atlantic City (1)
Swain, Richard D., 211 Roseville av., Newark (7)	Williams, R. A., 7207 Atlantic av., Ventnor (1)
Symes, Earl R., 161 Kearny av., Kearny (7)	Yagol, Benjamin, Bonnie Burn San., Scotch Pls. (20)
Taffet, Wm., 379 Union av., Belleville (7)	Young, John H., 37 N. Fullerton av., Montclair (7)
Taylor, Harold W., 247 Mountain rd., Englewood (2)	Zacchino, Arnold, 1001 Anderson av., Palisade (2)
Trehwella, Arthur P., 809 Montgomery st., Jersey City (9)	Zuck, John A., Netcong (14)
Turner, I., 141 Sheffield av., Englewood (2)	Zvaifler, Nathan, 46 Wilbur av., Newark (7)

VOTES OF LEGISLATORS

The two following tables are records of the votes of the members of the 1939 New Jersey Legislature, on Medical Bills:

(Similar tables of votes in the session of 1938 are printed in the October, 1938, Journal, page 644.)

SENATORS

		BILLS APPROVED BY THE MEDICAL SOCIETY OF NEW JERSEY				BILLS OPPOSED BY THE SOCIETY		
COUNTY	SENATOR	S-92	S-93	S-94	A-210	A-62	A-470	S-205
Atlantic	Taggart	Yes	Yes	Yes	Yes	...	Yes	No
Bergen	Van Winkle	...	...	...	Yes	Yes	...	...
Burlington	Powell	Yes	Yes	Yes	Yes	...	...	Yes
Camden	Driscoll	Yes	Yes	Yes	Yes	Yes	Yes	No
Cape May	Scott	...	...	...	Yes	Yes	Yes	Yes
Cumberland	Stanger	Yes	Yes	...	...	Yes	Yes	Yes
Essex	Zink	...	...	...	No	Yes	Yes	...
Gloucester	Hendrickson	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hudson	Stout	Yes	Yes	Yes	No	Yes	Yes	Yes
Hunterdon	Foran	Yes	Yes	Yes	No	Yes	Yes	Yes
Mercer	Jamieson	...	...	...	No	...	...	Yes
Middlesex	Toolan	...	...	...	...	Yes	...	Yes
Monmouth	Proctor	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Morris	Kelley	...	...	Yes	Yes	...	...	...
Ocean	Allardice	...	...	...	Yes	...	Yes	Yes
Passaic	Gardner	Yes	Yes	Yes	Yes	Yes	Yes	...
Salem	Summerill	Yes	Yes	Yes	Yes	Yes	...	No
Somerset	Bowers	Yes	Yes	Yes	Yes	Yes	Yes	No
Sussex	Dolan	...	...	...	Yes	Yes	Yes	No
Union	Loizeaux	Yes	Yes	...	Yes	Yes	Yes	Yes
Warren	Runyon	...	...	...	Yes	Yes	Yes	No

ASSEMBLYMEN

BILLS APPROVED BY THE MEDICAL
SOCIETY OF NEW JERSEYBILLS OPPOSED BY
THE SOCIETY

COUNTY	ASSEMBLYMAN	S-92	S-93	S-94	A-210	A-62	A-470	A-668
Atlantic	Farley	Yes	Yes	Yes	Yes	No	No	Yes
	Haneman	Yes	Yes	Yes	Yes	No	No	Yes
Bergen	Bogle	...	...	...	No	Yes	Yes	Yes
	Freund	...	...	...	Yes	No	No	No
	McClave	Yes	Yes	Yes	Yes	No	No	Yes
	Schroeder	...	...	...	No	...	...	Yes
	Smith	Yes	Yes	Yes	Yes	...	...	Yes
Burlington	Stokes	Yes	Yes	Yes	Yes	No	No	Yes
Camden	Palese	...	...	...	Yes	No	Yes	Yes
	Willson	...	...	...	Yes	No	Yes	Yes
	Worrell	Yes	Yes	...	Yes	No	Yes	Yes
Cape May	Boswell	...	...	...	...	...	...	Yes
Cumberland	Hancock	Yes	Yes	Yes	Yes	No	Yes	Yes
Essex	Cavicchia	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Ferster	Yes	Yes	Yes	No	...	...	Yes
	Glickenhau	Yes	Yes	Yes	No	Yes	Yes	...
	Hand	Yes	Yes	Yes	No	Yes	No	Yes
	Hargrave	...	...	...	Yes	Yes	Yes	Yes
	Huntington	Yes	Yes	Yes	Yes	Yes	Yes	...
	Mahr	Yes	Yes	Yes	...	Yes	Yes	...
	Orben	Yes	Yes	Yes	Yes	Yes	Yes	...
	Platts	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Sanford	Yes	Yes	Yes	No	Yes	Yes	Yes
	Wegrocki	...	...	...	Yes	Yes	Yes	Yes
	Williamson	Yes	...	Yes	Yes	No	No	Yes
Gloucester	Sholl	...	...	Yes	Yes	No	No	Yes
Hudson	Artaserse	Yes	Yes	Yes	Yes	Yes	Yes	No
	Beronio	...	...	...	Yes	...	Yes	...
	Boyle	Yes	Yes	Yes	...	Yes	Yes	No
	Cassin	Yes	Yes	Yes	No	...	...	No
	Czachorowski	Yes	Yes	Yes	Yes	Yes	Yes	No
	Friedland	Yes	Yes	...	...	Yes	Yes	No
	Littauer	...	...	...	Yes	Yes	Yes	...
	Maloney	Yes	Yes	Yes	No	...	...	No
	Schaeffer	Yes	Yes	Yes	Yes	Yes	Yes	No
	Wilson	...	...	...	No	...	...	...
Hunterdon	Lance	Yes	Yes	Yes	Yes	Yes	Yes	...
Mercer	Browne	...	...	...	No	...	...	No
	Connolly	Yes	Yes	Yes	No	...	...	Yes
	Ward	...	...	...	No	Yes	Yes	Yes
Middlesex	DeVoe	Yes	Yes	Yes	Yes	No	...	No
	Johnson	...	...	...	Yes	Yes	Yes	...
	Vogel	...	...	...	Yes	...	...	...
Monmouth	Herbert	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	McDermott	Yes	Yes	...	Yes	Yes	Yes	Yes
Morris	Lum	Yes	Yes	Yes	Yes	No	No	Yes
	Pierson	Yes	Yes	Yes	No	Yes	Yes	Yes
Ocean	Wickham	...	...	...	Yes	Yes	Yes	Yes
Passaic	Donahue	Yes	Yes	Yes	Yes	...	...	Yes
	Doremus	Yes	Yes	Yes	No	Yes	Yes	Yes
	Hanna	Yes	Yes	Yes	No	Yes	Yes	Yes
	Wilensky	...	Yes	...	Yes	Yes	Yes	...
Salem	Featherer	...	...	...	Yes	No	No	...
Somerset	Hess	Yes	Yes	Yes	...	Yes	Yes	Yes
Sussex	Vasbinder	...	...	...	Yes	...	...	...
Union	Kerner	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Muir	...	...	...	...	Yes	Yes	Yes
	Pascoe	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Shepard	...	...	...	Yes	No	No	Yes
Warren	Shafer	...	...	Yes	No	...	...	No

THE MEDICAL DIRECTORY

Up to November 1, 1939, copies of the Medical Directory for New York, New Jersey, and Connecticut may be obtained directly from the Medical Society of the State of New York, 2 East 103rd Street, New York City, at three dollars per volume (pre-publication price). After the date of publication there will be no reduction in the set price of six dollars.

Under the former agreement with the publisher (who is no longer employed by the Medical Society of New York) an offer was made to provide the members of the New Jersey Medical Society with copies of the Directory at one dollar for the 1938 issue. This was an introductory offer made at a loss. The agreement was to continue in effect *provided* that

every member of the Medical Society voluntarily added one dollar to the annual assessment of the State Society to cover the cost of the Directory. The House of Delegates voted not to accept this offer.

In view of the fact that The Medical Society of New Jersey collects and prepares the data used in the Directory, and does this at its own expense, the special pre-publication price of three dollars is made available to the members of The Medical Society of New Jersey up to the date of publication, namely, November first.

Send your orders and checks directly to the Medical Society of the State of New York.

MEMBER STATE BOARD OF HEALTH

Dr. Robert P. Fischelis, Executive Secretary and Chief Chemist of the Board of Pharmacy of the State of New Jersey, has been appointed a member of the New Jersey State Board of Health. The appointment comes at a time when a new State Food, Drug and Cosmetic Act, similar to the Federal Food, Drug and Cosmetic Act, goes into effect in New Jersey.

Because of the more complete control over the manufacture and distribution of drugs, devices and cosmetics provided in the new State law, the legislature amended the State Health Act to add a pharmacist to the Board of Health, and Dr. Fischelis is the first pharmacist to hold this appointment, which is for a four-year term under the amended act.

THE SOCIETY FOR THE RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN OF NEW JERSEY

The Society for the Relief of the Widows and Orphans of Medical Men of New Jersey was founded in 1882 by Drs. Charles J. Kipp, Joseph Osborne, and Edward J. Ill. Its object is to provide financial assistance to the widows and orphans of deceased members along two lines:

1. Immediately after the death of a member an assessment is made upon the survivors; and three-fourths of the proceeds of the last assessment is at once paid to the widow or children.

2. Financial assistance to those widows and orphans in special need, granted by the Trustees of the Fund.

The last annual report of the Society covers the period of the fiscal year May 1, 1938, to April 30, 1939.

ROUTINE BENEFITS

A summary of the part which deals with ordinary receipts and expenses, is as follows:

Number of members 505

Amount received from assessments on the members	\$8,695.00
Amount paid to the heirs of deceased members	6,388.25
Amount transferred to the permanent fund	2,000.00
Operating expenses	784.33

SPECIAL BENEFITS

The income from the permanent fund is applied to donations to widows and orphans according to the judgment of the custodian of the fund. The report may be summarized as follows:

Value of the securities held by the custodians (national and municipal bonds, etc.)	\$61,699.69
Cash in banks	2,993.84
	<hr/>
	\$64,693.53
Returns from these investments during the year	\$ 1,461.62

During the fiscal year donations of \$785.00 were made to ten needy widows of deceased members.

The report cites a few examples of relief, among which the following case is typical:

"This widow has received \$780.00. She is in absolute poverty, her husband having died of a long and tedious illness which used up all of his savings. At one time he had a very lucrative practice. She is still on our list."

The affairs of the society are managed by

a Board of Trustees consisting of the following physicians:

E. J. Ill, President
R. N. Connolly, Vice-President
W. D. Miningham, Secretary
H. A. Tarbell, Treasurer

J. H. Rosecrans	R. H. Scott
E. Z. Hawkes	E. G. Wherry
B. T. D. Schwarz	Edgar A. Ill
F. W. Hagney	J. H. Lowrey
E. S. Sherman	Herbert A. Schulte

OBITUARIES

DR. DAVID MARKS

Dr. David Marks, of 298 Fourth Street, Jersey City, N. J., died at his office on Friday, September 16th, 1939. Death was caused by a pistol shot in the back of the head while talking over the telephone in his office, by an unknown assailant.

Dr. Marks was born in New York in 1893, and was a graduate of Flower Hill Hospital, New York, graduating in 1916. He interned at St. Francis Hospital, New York City, and the Jersey City Hospital, now the Medical Center. He was an operating surgeon at Fairmount Hospital for twenty years and

was a visiting surgeon of the Hudson County General Hospital since 1926.

Dr. Marks served over-seas during the World War as a Lieutenant in the Medical Corps. He was a member of the Jewish War Veterans, Rising Star Lodge, F. & A. M.; Jersey City Lodge, B. P. O. E. Also a member of the American Medical Association, Medical Society of New Jersey, and the Hudson County Medical Society.

Surviving are his wife, Mrs. Bessie Harris Marks; three sons, Jerome, eight; Lawrence, thirteen; and Robert, sixteen; and his father, Michael, of Brooklyn.

DR. GEORGE WILKINSON

Dr. George Wilkinson, of 144 Old Bergen Road, Jersey City, N. J., died Thursday, August 17th, 1939, at his home from arterio sclerosis.

Dr. Wilkinson was a native of Jersey City and was born in 1862. He was educated in the Jersey City schools, and received his pre-medical training at Williams College. He graduated from the Bellevue Medical School, New York, in 1882, and had

been practicing in Jersey City for fifty-five years.

Dr. Wilkinson was active in Masonic circles. He was a past-master of Bergen Lodge, No. 47, F. & A. M., and was also a member of Valley of Jersey City, Order of Scottish Rite, and of Salaam Temple, Newark. He was a member of the American Medical Association, Medical Society of New Jersey, and the Hudson County Medical Society.

DR. LEWIS MENDELSON

Dr. Lewis Mendelsohn, of 272 Montgomery Street, Jersey City, N. J., died at the Medical Art Center, New York City, on Saturday, August 26th, 1939, from coronary thrombosis.

Dr. Mendelsohn was born in Russia in 1872. He received his early education in Russia, and came to this country about fifty years ago. His medical education was obtained at the Baltimore Medical College, Baltimore, Maryland, from which he graduated in 1901.

He was a member of the Sons of Israel Synagogue, the Hebrew School, the Jewish Community Center, and the Hebrew Home for Orphans and Aged. He was also a member of the American Medical Association, Medical Society of New Jersey and the Hudson County Medical Society.

Surviving are his wife, Bertha, nee Altshul; three daughters, Mrs. A. B. Rosenthal, Abigail and Edith Mendelsohn; two sons, Robert E., a Jersey City attorney, and Leonard, president of the Beacon Chemical Company, New Brunswick.

WILLIAM DANA PURSELL

Dr. William Dana Pursell, 508 South Main Street, Phillipsburg, died on September 18th in the Easton Hospital, aged sixty-four years. He was born in Phillipsburg on July 12, 1875. He attended Lafayette College and studied medicine in the University of Pennsylvania, graduating in 1901. After

studying in Italy and Germany, he opened an office in East Orange, but spent the greater part of his life practicing medicine in his native town of Phillipsburg.

Dr. Pursell was a Mason, and an active member of the Warren County Medical Society.

DECEASED PHYSICIANS—NEW JERSEY

Data Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Thomas L. Caldrony	46	Aug. 2, 1939	Pompton Lakes	Ridgefield Pk.	Coronary thrombosis.
Howard Conover	61	Aug. 13, 1939	Union Twp., Ocean Co.	Same	Mitral regurgitation and arthritis deformans.
Frederick W. Hagney	71	Aug. 26, 1939	Newark	Newark	Myocardial degeneration.
F. Ashley Thomas	56	Aug. 9, 1939	Flemington	Same	Coronary thrombosis.
George Wilkinson	78	Aug. 17, 1939	Jersey City	Same	Arterio sclerosis.

NUMBER OF CHILDREN REPORTED AS RECEIVING STATE FREE BIOLOGICALS
FROM JULY 1, 1939, TO AUGUST 31, 1939

DIPHTHERIA TOXOID

County	Total to July 31	Month of Aug.	Total to Aug. 31	Average per Month
Atlantic	14	22	36	18.
Bergen	333	86	419	209.5
Burlington	8	11	19	9.5
Camden	572	75	647	323.5
Cape May	20	8	28	14.
Cumberland	6	3	9	4.5
Essex	1067	671	1738	869.
Gloucester	37	4	41	20.5
Hudson	165	1166	1331	665.5
Hunterdon	0	0	0	0.
Mercer	0	449	449	224.5
Middlesex	13	24	37	16.5
Monmouth	501	266	767	383.5
Morris	139	44	183	91.5
Ocean	0	0	0	0.
Passaic	604	119	723	361.5
Salem	3	12	15	7.5
Somerset	18	10	28	14.
Sussex	0	0	0	0.
Union	231	108	339	169.5
Warren	2	2	4	2.
Totals	3733	3080	6813	3406.5

SMALLPOX VACCINE

County	Total to July 31	Month of Aug.	Total to Aug. 31	Average per Month
Atlantic	0	20	20	10.
Bergen	473	295	768	384.
Burlington	34	69	103	51.5
Camden	83	143	226	113.
Cape May	20	12	32	16.
Cumberland	13	29	42	21.
Essex	721	197	918	459.
Gloucester	37	30	67	33.5
Hudson	335	1211	1546	773.
Hunterdon	7	2	9	4.5
Mercer	0	267	267	133.5
Middlesex	19	88	107	53.5
Monmouth	83	26	109	54.5
Morris	165	67	232	116.
Ocean	18	0	18	9.
Passaic	317	213	530	265.
Salem	7	47	54	27.
Somerset	145	39	184	92.
Sussex	0	0	0	0.
Union	226	148	374	187.
Warren	14	33	47	23.5
Totals	2717	2936	5653	2826.5

THE WOMAN'S AUXILIARY

The Woman's Auxiliary to The Medical Society of New Jersey, which was founded on June 9, 1927, has initiated its thirteenth year by issuing a twenty-page program on the theme "An Informed Membership". The organization had been proposed to the Annual Meeting of The Medical Society of New Jersey on June 17, 1926, by representatives of the Auxiliary to the American Medical Association, which had demonstrated its usefulness over a period of four years. (Transactions, 1926, page 10.)

At the Annual Meeting of The Medical Society of New Jersey on June 9, 1927, Mrs. Samuel Barbash, Chairman of the Organization Committee, reported that Auxiliaries had been organized in fourteen counties of New Jersey, and the House of Delegates authorized the formation of a State Auxiliary. (Transactions, 1927, page 53.)

It was evidently the intention of the House

of Delegates that the newly formed Auxiliary should function under the direction of The Medical Society of New Jersey, and be an auxiliary in carrying out the doctors' activities in Public Relations; but unfortunately the Auxiliary seems to have been left to its own resources.

The Journal of July, 1934, lists a Committee on the Art and Hobby Exhibit; which, since November, 1935, has been listed an Advisory Committee to the Woman's Auxiliary.

The attitude of this committee is that it will advise the Auxiliary when its opinion about a specific activity is asked. The present handbook of the Auxiliary demonstrates that the organization can be a valuable adjunct if the committee *directs* it without waiting to be asked for its advice.

Procure a copy of the handbook, and note the items in which the Auxiliary is ready to assist the Medical Society in its projects.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

OCTOBER, 1939

3 Camden	12 Somerset
3 Cape May	13 Atlantic
3 Hudson	13 Salem
10 Bergen	17 Warren
10 Cumberland	18 Middlesex
11 Mercer	19 Gloucester
11 Ocean	19 Morris
12 Burlington	24 Hunterdon
12 Essex	25 Monmouth
12 Passaic	

NOVEMBER, 1939

7 Camden	9 Somerset
7 Hudson	10 Atlantic
8 Mercer	10 Salem
8 Ocean	14 Bergen
8 Union	15 Middlesex
9 Burlington	16 Gloucester
9 Essex	16 Morris
9 Passaic	22 Monmouth

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held at the Hotel Ambassador in Atlantic City September 8, 1939, at 9 p.m., with the newly elected President, Dr. Edward F. Uzzell, presiding.

SCIENTIFIC

Dr. John A. Kolmer of Temple University Medical College delivered a most comprehensive review of the recent knowledge of the use of sulphanilamide in bacterial infections. Particular stress was laid on the fact that the indication for the use of sulphanilamide or its derivatives is based on a bacteriological rather than clinical analysis of the case. Dr. Kolmer emphasized the importance of sufficient dosage to obtain a therapeutic effect. He mentioned several instances of alleged failure with the drug when analysis of the cases proved that the dosage was inadequate. It is frequently necessary to exceed the accepted scale of doses in order to meet specific needs. The toxic effects were enumerated and the need of frequent blood counts especially emphasized.

The discussion was opened by Dr. Kilduffe and Dr. Sloan Stewart. A general discussion which featured the citing of many individual cases followed.

DUES

The annual dues were fixed at \$4.00, plus the State assessment.

TUBERCULOSIS

The Secretary was instructed to address a letter to the Board of Freeholders reaffirming the previous resolution of the society relative to the need of new and modern facilities for the treatment of cases of tuberculosis in this county. The society went on record favoring the most recent plan of the Board for the construction of a new building at Northfield to replace the present facilities at Pine Rest.

BERGEN COUNTY

A. T. V. Brennan, Jr., M.D., Reporter

The first regular Fall meeting of the *Bergen County Medical Society* was held at the Englewood Hospital, Englewood, New Jersey, on September 12th, 1939.

PLANS

The President, Dr. G. Milton Knowles, outlined his plans for the coming year. It is hoped to stress the need for improvement in office practices and procedures in general, in order to strengthen physician-patient relationships, and to combat the ever increasing tendency of the layman to promote State Medicine. With this in mind, a portion of each regular meeting will be devoted to the discussion of the common problems of office practice. It is also hoped to bring this portion of medical practice more forcibly to the attention of the members through the *Bergen County Bulletin*.

MEMBERSHIP

A number of applications for membership were received as follows: For regular membership, three; for junior membership, five.

SCIENTIFIC

Dr. William Wolfe, Endocrinologist at the French Hospital in New York, addressed the meeting on "Practical Endocrinology". Following the conclusion of his talk there was a general discussion from the floor.

NECROLOGY

It is with deep regret that we announce the death of Dr. Thomas Leo Caldrony, of Ridgefield Park, on August 2, 1939. He had been in practice for more than twenty years in Ridgefield Park and was active in the Rotary, Masonic Club, and others. Dr. Caldrony served as Secretary to the Medical Society in 1926.

BURLINGTON COUNTY

Paul R. Sparks, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field

Club on September 14th, 1939. President Munro called the meeting to order at 9:35 p.m., and welcomed Drs. Diverty, Wood, Siddall, and Ziccardi as guests.

One proposition for membership was received.

LEGISLATION

Dr. Kuder, reporting for the State Committee on Legislation, stated that the State Society office has offered to send a staff member down to Burlington County to keep our legislators informed on the status of medical legislation. After some discussion a motion was made, seconded, and carried that in the opinion of the Society the offer is premature, and that action should be deferred until after the coming election, when we would know who our legislators would be.

SCHOOL MEDICAL EXAMINERS

The Secretary presented a communication from Mrs. Ruby R. Freer, Executive Secretary of the Burlington County Tuberculosis League, asking the coöperation of the Society in regards to a proposed one-half day institute on the problems of doctors who examine and supervise the health of school children, either in their offices or in the schools. It is suggested that a capable person, an authority in this field, be asked to meet with the physicians for lecture and discussion at a meeting in the early Fall. On motion made, seconded and carried the society agreed to coöperate with Mrs. Freer in the proposed institute.

SCIENTIFIC

In the absence of Dr. Shipps, President Munro turned the meeting over to Dr. Geary, who presented the speaker of the evening, Dr. William A. Lell, Chief Bronchoscopist at the Episcopal Hospital, Philadelphia, Pa. Dr. Lell gave a comprehensive and instructive talk on "Cancer of the Larynx", illustrating his remarks with lantern slides and motion pictures.

ACADEMY OF MEDICINE

Franklin J. Tobey, M.D., Secretary

The *Academy of Medicine of Northern New Jersey* has the following program for November, 1939:

Council meeting—Thursday, November 2.

Section on Obstetrics and Gynecology—Thursday, November 2, 1939, 8:45 p.m.

Paper: The Value of X-Ray Pelvimetry in Obstetrics; by D. Anthony D'Esopo, M.D., Associate Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University.

Section on Eye, Ear, Nose and Throat—Monday, November 13, 1939, 8:45 p.m.

Paper: The Non-surgical Treatment of Chronic Sinusitis, Arthur Palmer, M.D., Director of the Department of Otolaryngology, New York Hospital, Cornell Medical College.

Stated meeting under the auspices of the Sections on Medicine and Pediatrics—Thursday, November 16, 1939, 8:45 p.m.

Paper: Acute Laryngo-Tracheo Bronchitis, with Membrane Formation, Nathan Zvaifler, M.D.

Paper: Newer Treatment Methods for the Respiratory Diseases of Childhood, Bela Schick, M. D., Clinical Professor of Pediatrics, College of Physicians and Surgeons, Columbia University.

Lecture to the doctors and their friends, under the auspices of the Committee on Public Health and Medical Education—Tuesday, November 21, 1939, 8:45 p.m.

Paper: The Modern Trend of Medical Education, Currier McEwen, M.D., Dean, New York University College of Medicine.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* held its first monthly meeting of the 1939-1940 season on Thursday night at the Homestead, Woodbury, with the following members present: Drs. Bowersox, Diverty, Moore, Nelson, Pegau, Sherman and Underwood, of Woodbury; Collins, Pedrick and Venturo, of Glassboro; Burkett and Wright, of Pitman; DeMarino, Sheets, Sinexon, Sirotta and Wood, of Paulsboro; Campo, Hollinshed and Patterson, of Westville; Gairdner and Ulmer, of Gibbstown; Livengood, of Swedesboro; Weems, of Wenonah; Ruttenberg, of Mantua, and Serri, of Mullica Hill.

SCIENTIFIC

After the usual reports there was a discussion of current health problems, particularly concerning infantile paralysis.

The speaker of the evening was Dr. John A. Kolmer, Professor of Medicine at Temple University School of Medicine. Professor Kolmer's subject was "Recent Advances in the Treatment of Bacterial Diseases, with Special Reference to Sulphanilamide".

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* held on Tuesday, May 2, 1939, at the Carteret Club was called to order by the President, Dr. H. L. Ballinger at 9:45 p.m.

Dr. H. B. Ainsley, for the Auditing Committee, reported that the Treasurer's accounts were correct and in proper form.

PUBLICATION COMMITTEE

"The members of the Publication Committee have given the society a new Bulletin beginning with the February issue. We have secured some additional advertising matter which pays for its publication with a small profit; however, your committee expects a greater amount of advertising and a better Bulletin, as the new advertising budgets are made up by the various national advertisers.

"I wish to thank my committee for all their efforts, and especially Dr. Nicholas Alter, the Editor,

for the great amount of time and hard work he has given in the publishing of the Bulletin, which we all appreciate.

"We are looking forward with much assurance to the issue of the best Bulletin the society has ever had.

"W. JAY SNYDER, *Chairman.*"

PUBLICITY COMMITTEE

"The Publicity Committee of the Hudson County Medical Society wishes to report that the past year has seen a greater and better amount of publicity for our society.

"We have supplied more speakers for various occasions as civic organizations, Parent-Teachers, etc., than last year. We have also supplied addresses on medical subjects to a school system in Bergen County. Our column 'The Doctor Says' will be found in the Bayonne News, Jersey Journal, Jersey Observer, and Hudson Dispatch weekly.

"Our 'Radio Health Programs' over Station WAAT have had the best year thus far. We have had a speaker from our society on the air every Friday for the past year. The programs have been of a higher order with a variety of subjects taken from the whole field of medicine. The speakers were representative doctors from all parts of the county.

"The quality and demand for these programs is further proven by fan mail and mailing lists, which have increased greatly over last year, which we felt was our best year.

"We supplied the speakers for 'The Health Observance Week' conducted by the State Y. M. C. A. of Hoboken and Jersey City during the week of March 26th to April 1st.

"W. JAY SNYDER, *Chairman.*"

MEMBERSHIP COMMITTEE

Dr. W. T. Callery, Chairman of the Membership Committee, reported that the paid-up membership was now 444, and that the Membership Committee will continue to comply with the suggestions of The Medical Society of New Jersey to increase the membership during the coming year.

POST-GRADUATE COMMITTEE

"The Post-Graduate Committee has arranged a series of eight lectures in pathology to be given by Dr. Paul Klemperer, Pathologist at Mount Sinai Hospital, on Thursday evenings during May and June, 1939. Thus far nineteen physicians have made application to take the course, and probably the names of some other physicians will be added to our list before the first lecture on Thursday, May 4, 1939.

"THOMAS J. WHITE, *Chairman.*"

NEW MEMBERS

Five physicians were proposed for membership. Three physicians were elected to membership:

Katherine Delanty, Jersey City

Paul F. Sinclair, Jersey City

James J. Nobile, Hoboken

Dr. R. L. Ballinger stated that there was a va-

cancy on the list of Delegates due to the death of Dr. M. S. Granelli, for 1939.

Dr. W. Jay Snyder nominated Dr. Andrew C. Ruoff. Seconded by Dr. W. F. Callery.

Dr. J. F. Norton moved that nominations be closed. Seconded. So ordered!

Dr. Andrew C. Ruoff was elected delegate to House of Delegates of the State Society to fill the vacancy resulting from the death of Dr. M. S. Granelli.

SCIENTIFIC SESSION

Dr. Ballinger introduced Dr. Harvey B. Matthews, Clinical Professor of Obstetrics and Gynecology, Long Island College of Medicine, whose subject was "An Intimate Talk on Common Obstetrical Problems".

Discussors: Drs. Cosgrove, Norton, Swiney, Waters, Hall, terminated by Dr. Matthews.

The Public Health Committee reported that it had a conference with a group of Negro physicians; and recommend that one member, at least, of this organization be included in the selection of members of the Public Health Committee hereafter. We feel that this is a constructive suggestion.

The present method of garbage collection in many communities in Hudson County is subject to considerable and justified criticism. After a preliminary discussion of the problem with a member of the Jersey City Board of Health it was decided to again request a conference with the city authorities for the purpose of discussing ways and means of improving the situation.

ABRAHAM E. JAFFIN, *Chairman.*

LEGISLATION

Dr. B. S. Pollak reported for the Committee on Legislation that while Assembly Bill 510 had been enacted by the Legislature, a bill in favor of the chiropractors had been reported by the Judiciary Committee of the Senate. Therefore the work of the Committee on Legislation is not yet completed.

MATERNAL WELFARE

The Maternal Welfare Committee, through Dr. A. Cosgrove, chairman, exhibited a copy of the Standard Delivery Room Record which had been compiled by the State committee. The county committee approved it, and voted to urge its adoption throughout the county.

The yearly obstetric reports from the several hospitals in Hudson County were reviewed by the committee, and suggestions were made to improve the record during the coming year.

ELECTION

Dr. W. M. Doody, Chairman of the Election Committee, reported that the following names have all been certified as duly elected:

President, J. F. Norton

Vice-President, G. Ginsberg

Treasurer, H. Spence

Secretary, T. McG. Brennock

Reporter, J. N. Connell

Board of Trustees, 3 years to 1942: W. J. Gleeson
Board of Censors, 3 years to 1942: R. L. Ballinger
Audit Committee, 3 years to 1942: H. B. Ainsley
Publication Committee, 3 years to 1942:

P. Kresch J. D. Pelarin
N. M. Alter M. Fellman

Delegate to State Nominating Committee, to serve in 1940: J. F. Londrigan

Alternate to State Nominating Committee, to serve in 1940: F. J. McLoughlin

Committee on Constitution and By-Laws, 3 years to 1942: A. C. Ruoff

Legislative Committee, 3 years to 1942:

M. Shapiro W. D. Weber
G. B. Spath

Delegates to State Convention, 3 years to 1942:

E. J. Chapman R. L. Ballinger
T. J. Schuck C. J. Larkey
B. S. Pollak J. J. Quinn
S. A. Cosgrove G. Ginsberg
J. L. Evans W. W. Maver

Alternates to State Convention, 3 years to 1942:

E. E. Lupin A. Schlein
J. S. Madaras J. P. Donnelly
J. J. O'Connor S. I. Kooperstein
H. Fialk W. J. Snyder

Election Committee, to serve in 1940:

S. G. Scott J. J. Danielson
L. A. Schneider M. Shapiro
D. D. Dougherty S. S. Schept
W. E. Doody

Maternal Welfare Committee, 3 years to 1942:

J. F. Norton W. A. Pinkerton
S. A. Cosgrove
2 years to 1941:
A. O. Largay

Nominating Committee, to serve in 1940:

A. J. Conty J. A. Botti
W. T. Callery C. J. Larkey
E. J. Daly

INSTALLATION OF PRESIDENT NORTON

Dr. J. F. Norton was conducted to the President's chair, and introduced as the new President of the Society.

OCEAN COUNTY

L. Roberto Carmona, M.D., Reporter

The first Fall meeting of the *Ocean County Medical Society* was held at the Carlton Hotel, Tucker-ton, N. J., September 13th, 1939, at 8 p.m. After an excellent dinner the regular order of business was called by our President, Dr. J. E. Obert. Those present were: Drs. Bunnell, Buermann, Carmona, Dodd, Henriksen, Gaumer, Herbener, Frazee, Ivory, Menge, Obert, Sickel, Taylor, Towbin, Schneider, and Witte.

CONSTITUTION AND BY-LAWS

Most of the evening was devoted to the first reading of the revision of the Constitution and By-Laws as presented by the chairman of the committee, Dr. Dodd. Among some of the changes are the limitation in the number of committees; three

to be appointed, the executive, membership and nominating, a board of trustees and a historian. Other changes concerning duties of officers, and dues and meetings were suggested; and the word physician to be changed to M.D.

INDIGENT TONSILLECTOMY CASES

Drs. Buermann and Taylor reported to the attention of the Society to indigent cases sent to Paul Kimball Hospital for tonsillectomy by the Department of Health, without being previously examined physically. This will require extra work for the surgeons, who do not get any compensation for their work. They also suggested that the parents and public should be informed that the county does not pay them for this work as is the general belief. The case was referred to the committee to take it up with the Department of Health.

SCHOOL PHYSICIAN

Dr. Bunnell informed the Society that a certain Board of Education has requested the school physician to do first aid. Another school board refuses to accept certificates from family physicians of illness, disability, or recovery from contagious diseases. They claim the school physician should pass on these cases. The secretary was instructed to write to the different boards of education informing them that the Medical Society considers such acts as unethical to the profession.

The meeting was adjourned at 11:30 p.m.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on September 14, 1939, at the North Jersey Training School, Totowa, N. J. Wayne Hall, M.D., President, presided at the meeting, and Irving Okin, M.D., acted as secretary in the absence of Dr. Yager.

Before the meeting opened the members made an inspection tour of the hospital and class rooms. Great satisfaction was expressed by the members at seeing this institution, and all were appreciative of the fine hospitality extended by Mr. Meese, the superintendant, and his staff.

NECROPSIES

The report of the Committee on Necropsies, which had been published in July in the Bulletin, was adopted. This report was from the joint meeting of the Funeral Directors' Associations and Committee of the Medical Association, in approving certain definite measures in autopsy procedures, and to work out a scheme of necessary cooperation between the funeral director and physician. The result should be more autopsies by the hospitals, and no objections from the funeral directors.

NEW MEMBERS

Dr. H. E. Reading, Paterson, was elected to membership. Dr. William C. Giordano, Paterson, was elected to associate membership.

Two applications for active membership and one for associate membership were received.

SCIENTIFIC

Dr. Hall then introduced Dr. James S. Plant, Director of the Essex County Juvenile Clinic of Newark, whose subject was "Child Guidance".

Dr. Plant traced the history of the Child Guidance Clinic, and pointed out its development from the Mental Hygiene Clinic. Its purpose was the study of the problems and personalities, conduct and habits; he also pointed out that many cases involved rebellion of the child against his surroundings, and that the environment may be the problem and not the child. He spoke of parental defects in the handling of the child, and the problems of childhood in relation to the point of view of the child.

Many questions were asked and a large audience heard the talk, which was followed by a collation in the dining room.

SUSSEX COUNTY

H. M. Aitken, M.D., Secretary

The following is a list of officers and committee chairmen of the *Sussex County Medical Society* for the year 1939-40:

President, A. H. Groeschel, Sussex
Vice-President, Jesse McCall, Newton (Pres.-Elect)
Secretary, H. M. Aitken, Ogdensburg
Treasurer, V. E. Burn, Newton
Delegate, Jesse McCall
Alternate, F. J. Scott, Franklin
Member Nominating Committee, Jesse McCall
Alternate, J. E. Longenecker, Sparta
Reporter, E. K. Hawke, Newton
Censors—

D. L. Spurgeon, Newton, 1941
J. H. Spencer, Franklin, 1940
L. B. Drake, Franklin, 1939

Trustees—

E. W. Landes, Stillwater, 1940
W. K. Smith, Newton, 1941
F. H. Morrison, Newton, 1942

COMMITTEE CHAIRMEN

Welfare—J. H. Spencer
By-Laws—W. H. Smith
Public Relations—E. K. Hawke
Crippled Children—F. W. Morrison
Child Health—E. J. Longenecker
Conservation of Vision—D. C. Braun, Newton
Maternal Welfare—H. M. Aitken
Tuberculosis—L. B. Drake
Workmen's Compensation—D. L. Spurgeon
Venereal Disease—Martin Kirschner, Vernon

The President plans to call meetings of the society for October 11, January 17, and May 15.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

On Wednesday evening, September 20th, 1939, the first Fall meeting of the *Union County Medical Society* was held at St. Elizabeth's Hospital in Elizabeth. President Roland P. Blythe presided.

MEDICAL SERVICE BUREAU

Dr. Thomas Walsh, of Elizabeth, spoke at length of the progress of our Medical Service Bureau,

drawing attention to the fact that in the last eight months, while under the management of Dr. Faulkner-Slater, a small profit has been shown each month. However, there is still a deficit of \$500.00 incurred under the old management. This is an extremely creditable showing, as the expenses of the central office of the County Society have, for the most part, been assumed by the Medical Bureau.

Dr. W. B. Morris called attention to the fact that only forty per cent of our membership uses the Bureau, and he urged greater coöperation on the part of the doctors. Dr. Faulkner-Slater stated that if only two new accounts were received from each doctor each month, this alone would insure the continued success of the enterprise.

Dr. W. B. Morris made a motion that the County Treasurer be asked to advance this \$500.00, which would be gradually paid back out of the profits of the Medical Bureau. This was discussed at length by the members present, and feeling that we should continue our support of the Bureau, when put to a vote, the motion was passed.

Dr. Faulkner-Slater was given a vote of thanks for her efforts in making the meeting of the Professional Guild, held last week, a great success.

Dr. Blythe announced that the next meeting would be held at the Bonnie Brae Sanitarium.

Meeting was adjourned, following which refreshments were served by the hospital management.

PROFESSIONAL GUILD OF UNION COUNTY

Many doctors, nurses, pharmacists, and dentists met September 15, 1939, at the Elizabeth General Hospital to revive the Professional Guild of Union County, which first had its inception in 1921.

The purpose of this organization is to bring about more friendly relations, increase mutual coöperation, and foster a coördination of effort in the interests of these professions.

Many of the candidates for election in the Union County Primaries were present, and letters were read from several others who were unable to attend.

Guild officers elected for the coming year were:

President, H. V. Hubbard, M.D., Plainfield
Vice-President, Charles Murphy, D.D.S., Elizabeth

Secretary, Walter Kerner, Pharm., Elizabeth
Treasurer, Lois Simpson, R.N., Overlook Hospital, Summit.

SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The *Summit Medical Society* opened its first meeting of the season at the Beechwood Hotel on Tuesday evening, September 26th, 1939.

A dinner was held on the East Porch followed by the scientific meeting in the auditorium. There were twenty-seven members and nine guests present.

Dr. A. S. Price, Professor of Pathology, of New York Polyclinic Hospital, gave an instructive, illustrated presentation on "Pathological Lesions of the Liver with Special Reference to Barbiturate Degeneration".

BOOKS RECEIVED

Treatment in General Practice; the management of some major medical disorders. Price, \$7.50. 2 vols. Pp. 695. Boston, Mass., Little Brown & Co. 1939.

Gastrointestinal Dysfunction, by Barton A. Rhinehart, M.D. Price, \$6.00. Pp. 311, 48 plates. Little Rock, Arkansas. Central Printing Co. 1939.

Life and Letters of Dr. William Beaumont, by Jesse S. Myer, A.B., M.D., with an introduction by Sir William Osler, Bt., M.D., F.R.S. A new print. Price, \$5.00. Pp. 327. St. Louis, Missouri, C. V. Mosby Co. 1939.

Heart Patients: Their Study and Care, by S. Calvin Smith. Price, \$2.00. Pp. 166. Philadelphia, Lea & Febiger. 1939.

Varicose Veins, by Alton Ochsner and Howard Mahorner. Price \$3.00. Pp. 147. St. Louis, Mosby. 1939.

Diseases of the Nose and Throat, by Charles J. Imperatori, M.D., and Herman J. Burman, M.D. Pp. 726. Philadelphia, Pa., J. B. Lippincott Co. 1939. Second edition revised. 480 illustrations.

Cancer Handbook of the Tumor Clinic, Stanford University School of Medicine. Edited by Eric Liljencrantz, M.D. 50 illustrations. \$3.00. Pp. 114. Stanford University, California, Stanford University Press. 1939.

What It Means to Be a Doctor, by Dwight Anderson. Pp. 87. Public Relations Bureau, Medical Society of New York, New York City. 1939.

Alcoholics. Anonymous. \$3.50. Pp. 400. New York City, Works Publishing Company. 1939.

Syphilis, by George M. Katsainos, M.D. Pp. 676. Privately printed at Athens, Greece, by Kyklos Publishing Co.

Otolaryngology in General Practice. Lyman G. Richards. Pp. 352. Price \$6.00. New York, The Macmillan Co. 1939.

The Mental Hygiene Movement from the Philanthropic Standpoint. Privately printed. Pp. 73. New York: Central Hanover Bank & Trust Co. 1939.

Fever and Psychoses: A study of the literature and current opinion on the effects of fever on certain psychoses and epilepsy. By Gladys C. Terry. Pp. 167. Price \$3.00. New York, Paul B. Hoeber. 1939.

Medicolegal Phases of Occupational Diseases, by C. O. Sappington. Pp. 400. Price \$2.75. Industrial Health Book Co., Chicago. 1939.

Pseudocyesis, by George Davis Bivin and M. Paulice Klinger. Pp. 265. Bloomington, Indiana, The Principia Press. 1937.

Epidemic Encephalitis—Third Report by the Matheson Commission. Price \$3.00, 178 pp., 322 pp. bibliography. N. Y. Columbia University Press.

The Art of Anesthesia, by Paluel J. Flagg, M.C. Sixth Edition revised; 161 illustrations; pp. 491. Philadelphia, J. B. Lippincott Co.

Functional Disorders of the Foot—Their Diagnosis and Treatment, by Frank D. Dickson, M.D., and Rex L. Diveley, M.D. Price \$5.00; pp. 305; illustrated. Philadelphia, J. B. Lippincott Co.

BOOK REVIEWS

CHRONIC DISEASES OF THE ABDOMEN, A DIAGNOSTIC SYSTEM. By C. Jennings Marshall, M.S., M.D. (Lond.), F.R.C.S. (Eng.), Surgeon, Charing Cross Hospital and Victoria Hospital for Children; Surgical Consultant, L. C. C. and Bromley District Hospital; Examiner in Surgery, London University and Victoria University, Manchester. Boston, Little Brown & Company. 1939. Pp. 247. \$6.00.

Diagnostic systems are, at best, difficult to execute in a satisfactory, comprehensive manner. The author of this work has fortunately confined himself to the abdomen, and, excluding acute diseases, has organized his attack in an interesting sequence, particularly with relation to the location of pain. Although some will not agree with the arbitrary divisions, the material is handled in a clear and concise manner. The illustrations are well correlated with the text. This book should be of real value to all students and general practitioners, who will find therein important points emphasized in dark type. Part One on physical examination and various special investigations is excellent and could be read with profit by anyone. In their advent into the field of medical publication, Little, Brown and Company have done well.

C. A. BELING, M.D.

THE MENTAL HYGIENE MOVEMENT: From the Philanthropic Standpoint. Department of Philanthropic Information, Central Hanover Bank and Trust Company, New York. 1939. 73 pp. Cloth. Paper edition 25 cents. National Committee for Mental Hygiene, 50 West 50th Street, New York.

This book is a lucid and succinct survey of "The Mental Hygiene Movement". It is refreshing to note that the endeavor to bring it before the public has been actuated by an earnest desire to enlist for it the generous support it deserves. It is indeed a philanthropic undertaking in the truest sense. In a presentation of this kind, one cannot expect a full statement of the case, but it contains many references to works on mental disorders to serve the needs for deeper knowledge.

This small book of seventy-three pages has been carefully prepared. Everyone should read it. To the mind of the reviewer who has been identified with the Mental Hygiene Movement from its early days, this book should help greatly in promoting the further progress of this "greatest movement of all time".

CHRISTOPHER C. BELING, M.D.

ANUS, RECTUM, SIGMOID COLON: DIAGNOSIS AND TREATMENT, by Harry Ellicott Bacon, B.S., M.D., F.A.C.S., F.A.P.S., Assistant Professor of Proctology, Temple University School of Medicine; Visiting Proctologist, St. Luke's and Children's Hospital, etc. Introduction by W. Wayne Babcock, A.M., M.D., L.L.D., F.A.C.S. (Eng.). Philadelphia, J. B. Lippincott Co., 1938. Pp. 855. Cloth, \$8.50.

Dr. Bacon's excellent work deserves a place on every practitioner's shelf as a reference book, if for none of the other features which commend it. The extensive bibliographies which cover the important contributions on the several subjects during recent times, and the variety of procedures and methods described will be of particular interest to those who are and those who aspire to be specialists in this field. The general practitioner will also find here ready help and guidance. The section on the injection treatment of hemorrhoids is good and definitely states the contraindications. The chapters on venereal diseases and lymphopathia venereum are excellent. The reports of the use of sulphanilamide in the chemotherapy of the latter could have been mentioned although it is too early to come to any conclusions. One might also wish for some further evaluation of the various methods of treating pruritis ani.

As a whole, the scientific substance, the arrangement, the type, and the general appearance are much to the credit of both the author and the publishers.

TRAUMA AND INTERNAL DISEASE. By Frank W. Spicer, A.M., M.D., F.A.C.P. \$7.00. 1939. Philadelphia, Pa., J. B. Lippincott Co.

The purpose of this book is to present a study of the part played by *trauma* as a causative factor in the production of disease. The author presents the opinions of trustworthy and representative writers. The rôle which external trauma may play when superimposed upon preëxisting pathology has been a neglected study. From the medico-legal standpoint, correct evaluation is very important. The evidence presented should be overwhelming and leave no doubt.

The work provides a comparatively new study engendered by recognition of the broadened conception of the Compensation Laws, which take cognizance of the contributing influence of injury upon disease. In this book, we have an attempt to throw light upon dark and somewhat dangerous topics. Its quotations are abundant, and its illustrative case histories are numerous and well chosen. An excellent summary which is helpful follows each topic which is discussed. In the more controversial subjects discussion is preceded by current opinions.

The collected material on trauma and tumors is one of the best features of the book. In all humility, the author claims little originality. He has written a good book, and is to be congratulated. It should be part of the armament of the medical witness, but it is to be emphasized that the reader should do his own thinking, and not accept all as gospel.

ROYAL H. FOWLER, M.D.

MEDICO-LEGAL TEXT ON TRAUMATIC INJURIES. By Louis J. Gelber, M.D., L.L.B., F.A.C.M.-L. Cloth. Price \$6.00. Pp. 482. Newark, N. J. Soney & Sage. 1938.

In the foreword, the author says that with the aid of this simple manual, if counsel can more easily prepare his bills of particulars and acquaint himself with the medical injuries involved in the case, the book will have fulfilled its purpose. An examination of the contents of this admirable little book is convincing proof that it has amply fulfilled its purpose.

Dr. Harrison S. Martland has this to say about Dr. Gelber's book: "There are several medico-legal jurisprudence books on the market today. However, we find that if the author is a physician, the medical side is stressed. If he is a lawyer, the legal side is emphasized. But to have a book written by one acquainted not only with the medical but also the legal side is an advantage not found in other books on the subject."

Dr. Martland recommends the book not alone to the legal profession and arbitrators on medico-legal problems, but also to the medical profession for a better understanding of the various solutions of evaluation and disabilities in accidental injuries that they are called upon to adjudicate.

Dr. H. H. Kessler recommends this book with a great deal of pleasure to the legal profession. He says that there has been a long-felt need for a medical text written in a simple style to be used by attorneys. Their difficulty in understanding medical nomenclature and visualizing the bones of the body as well as fractures are known too well to the medical profession.

DISEASES OF THE SKIN. By R. L. Sutton, Professor of Dermatology, University of Kansas, School of Medicine, and R. L. Sutton, Jr., Associate in Dermatology, University of Kansas, School of Medicine.

This book is probably the most complete textbook on the diseases of the skin that has ever been written. Dr. Sutton's former editions were always comprehensive, and were an excellent guide for not only the student of dermatology, but for the practicing dermatologist. This edition far surpasses any of the others.

The various sections which have been contributed by outstanding dermatologists are excellent, and one is particularly impressed by the chapters on fungous infections. The illustrations and color plates are numerous and of great value. Dr. Sutton has drawn on his wide knowledge and long experience to describe therapy that he has found effective in various conditions of the skin, in conjunction with the other treatments that have been found successful. The chapter on diseases of the mucosa is very complete,—a feature which has been lacking in textbooks on dermatology previously.

This new edition of Dr. Sutton's book should be of great value not only to the general practitioner, but also to those who are specializing in dermatology.

BART M. JAMES, M.D.

SPINAL ANESTHESIA. By Louis H. Maxson. Cloth; pp. 409. Philadelphia, London, New York and Montreal, J. B. Lippincott Co. 1938.

"Spinal Anesthesia", by Louis H. Maxon, A.B., M.D., gives to the surgeon, spinal anesthetist and student anesthetist a long-sought-for reference book that should be in the library of every surgically-minded practitioner. The text is in straightforward, almost legendary, descriptive form. The author has presented his subject with evidence of a great deal of experience and thorough research investigation. No one didactic principle is laid down, although an opportunity is given the reader to follow the author's technic and selection of drug employed. The author's reasoning for his choice and the deductions gained from his résumé of contributions by other workers in the field, give the student an opportunity for study not readily afforded in the confines of any one book issued heretofore.

The author has compiled the facts in an orderly fashion, devoting chapters to history, anatomical and technical considerations, drugs and physical factors, that should never be omitted in the consideration of an attempt to produce a successful spinal anesthesia.

A. L. REICH, M.D.

MARIHUANA: America's New Drug Problem, by Robert P. Walton, Professor of Pharmacology, School of Medicine, University of Mississippi. J. B. Lippincott Company, New York. 1938. 213 pp. \$3.00.

The author has collected and summarized a vast literature on the hemp plant and hemp drugs. His book will prove to be of much value as a work of reference to serious students of the subject. It is a timely publication in view of the great sociological interest now being manifested in the alarming spread of its pernicious use in the United States as a narcotic stimulant.

One cannot review adequately such a book as this. The rapid growth of the marihuana habit in the United States especially among the younger generation who are able to disguise its use in the form of cigarettes, makes it a dreadful menace which can only be stamped out by a complete clearance of the plant from the face of American soil.

The scope of the work is comprised in a history of the hashish vice and distribution; the present status of the marihuana vice in the U. S. A., the public consciousness of the problem, etc.; the plant source; descriptions of hashish experience; its effects acute and chronic; its therapeutic applications; pharmaceutical and chemical considerations; quite a complete nomenclature and an extensive bibliography.

The drug is of little value and finds practically no place in the modern practice of medicine. Those interested in the various phases of the marihuana problem will find valuable data in Professor Walton's book.

CHRISTOPHER C. BEJING, M.D.

THE ART OF ANESTHESIA. By Paluel J. Flagg. 6th ed. Pp. 491. Philadelphia, J. B. Lippincott Co. 1939. \$6.

Dr. Flagg again presents another edition of his valuable text and reference book on anesthesia, which he prefers to be considered chiefly as an art in contradistinction to a mechanical procedure. Perhaps this is Dr. Flagg's subtle differentiation between a medically trained and a lay anesthetist.

The book is written in two sections. *Part one* deals with the types of anesthesia under headings of general, local and regional anesthetics. In each chapter the author is very meticulous in offering all that an experience of many active years under keen observation can give. Each notation is clear and in detail so necessary for the student and so assuring as a reference for the active professional anesthetist. *Part two* bears upon factors incidental to the administration of the anesthetics. Here this new edition is of particular value because Dr. Flagg's original contributions are stressed under the chapters of improved technic for intratracheal anesthesia and that of pneumatology. Artificial respiration, prevention of asphyxial deaths and oxygen therapy may well have been presented as individual monographs. But being part of this excellent publication, "The Art of Anesthesia" is well recommended to both surgeon and anesthetist.

A. L. REICH, M.D.

DAILY LOG FOR PHYSICIANS FOR 1940. Champaign, Illinois, Colwell Publishing Company. Thirtieth Edition.

Each year at this time we receive a copy of the Physician's Daily Log. It reminds us quite properly about the importance of proper bookkeeping to the doctor.

We have glanced through the 1940 Log and find that it is a complete repository for all the financial data which a physician should keep. As a matter of fact, we have not seen any other special day book and ledger which even approaches the usefulness of this book for the doctor.

We commend it highly.

S. T. S.

DISEASES OF THE NOSE AND THROAT. By Charles J. Imperatori, M.D., F.A.C.S., and Herman J. Burman, M.D., F.A.C.S. Published by J. B. Lippincott Company, Philadelphia, London, Montreal. Copyright 1939.

The favorable reception of the first edition of this text has warranted a second edition after three years, with several additions and corrections, and revision of the chapter on Orbital Infections.

New methods of laryngeal x-rays from Dr. Felix E. Leborgne, reproduced opposite page 504, are of special interest to laryngologists and roentgenologists.

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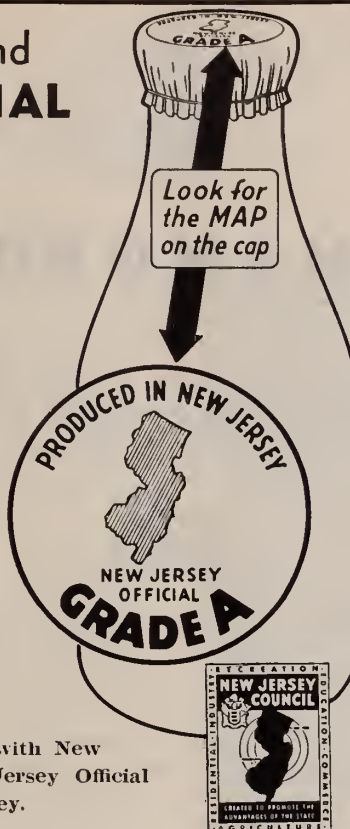
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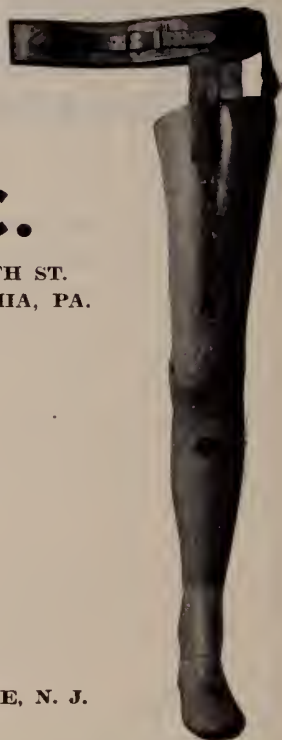
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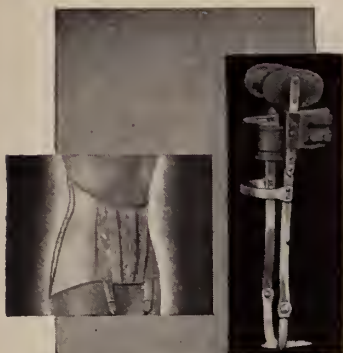
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*Frazer, J. G.: *The Golden Bough*, vol. 1, New York, Macmillan & Co., 1923



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There is no other milk exactly like Golden Guernsey—in flavor, food-values, or color. Its deep yellow results from an abundance of carotene, a primary source of vitamin A.

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SUMMIT, NEW JERSEY



METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

II. Determination of Ascorbic Acid

● The first practical method for quantitative estimation of vitamin C in foods was that evolved by Sherman and his associates in 1922 (1).

In this technique selected guinea pigs were confined to a scurvy producing ration supplemented with green succulent vegetables—a source of vitamin C—for a suitable period to demonstrate that the animals were growing at a normal rate. The supplementary feeding of succulent vegetables was discontinued when the animals had attained the proper weight, and the feeding of graded daily doses of the material under assay begun and continued over a 90-day period. At the end of this period, the animals were sacrificed and the degree of protection against pathologic changes characteristic of scurvy provided by the various dosages then was determined by dissection and examination of the organs and tissues. The quantity (daily dose) of the food required to prevent incidence of scurvy symptoms—the protective dose—eventually became known as the “Sherman Unit” for vitamin C, or the “minimum protective dose.”

This bioassay technique underwent gradual improvement, both as to the basal ration (2) and as to a numerical system of evaluating and recording the severity of the scurvy symptoms; the so-called “scurvy score” (3). Methods employing shorter assay periods, such as the formal preventive type of assay with a 60-day assay period (4), or a method based upon histologic exami-

nation of the teeth (5), as well as curative techniques (6), have been proposed and used for the determination of vitamin C activity of foods. However, today the improved Sherman bioassay technique employing ascorbic acid as a standard of reference and a relatively long assay period is still regarded as the standard method for vitamin C determination (7).

Some six years ago, a chemical method for ascorbic acid estimation was proposed (8, 9) and immediately came into widespread use. Judiciously and circumspectly used, this method has proven a most valuable tool. By acid extraction of a known quantity of food followed by removal of certain proximate food components, ascorbic acid present in the extract may be quantitatively titrated by a standard solution of 2,6-dichlorophenolindophenol. Under proper conditions this reagent is quantitatively reduced by ascorbic acid to a colorless compound. A faint pink color in the acid solution produced by one excess drop of the reagent indicates the completion of the oxidation-reduction titration.

Development of this chemical method has stimulated many researches on the ascorbic acid contents of foods, among them many canned foods (10). Results of investigations by the chemical or bioassay technique (11) reveal that the canned varieties of foods notable for their natural ascorbic acid contents can also be numbered among the most valuable sources of this dietary essential available to the American Consumer.

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| (1) 1922. J. Am. Chem. Soc. 44, 165. | (8) 1933. Ztschr. f. Untersuch. d. Lebensmitt. 65, 145. |
| (2) 1929. Am. J. Pub. Health 19, 1309. | (9) 1933. J. Biol. Chem. 103, 687. |
| (3) 1926. A Study of the Thermostability of Vitamin C. C. L. Kenny, Dissertation, Columbia University, New York. | (10) 1937. U. S. Dept. Agr. Miscellaneous Publication No. 275, 104. |
| (4) 1930. J. Agr. Research 41, 51. | (11) 1922. J. Am. Chem. Soc. 44, 172. |
| 1931. J. Agr. Research 42, 35. | 1925. Ind. Eng. Chem. 17, 69. |
| (5) 1926. Brit. J. Exper. Path. 7, 356. | 1926. Ibid 18, 85. |
| (6) 1933. Biochem. J. 27, 2006. | 1930. J. Home Econ. 22, 588. |
| 1936. Food Research 1, 3. | 1935. Am. J. Pub. Health 25, 1340. |
| (7) 1938. J. Am. Med. Assoc. 111, 1290. | 1938. J. Am. Med. Assoc. 110, 650. |
| | 1938. Ibid. 111, 2138. |

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the fifty-third in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.



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1 ASSAY—Before acceptance, each lot of cod liver oil is biologically assayed and classified according to its content of vitamins A and D.



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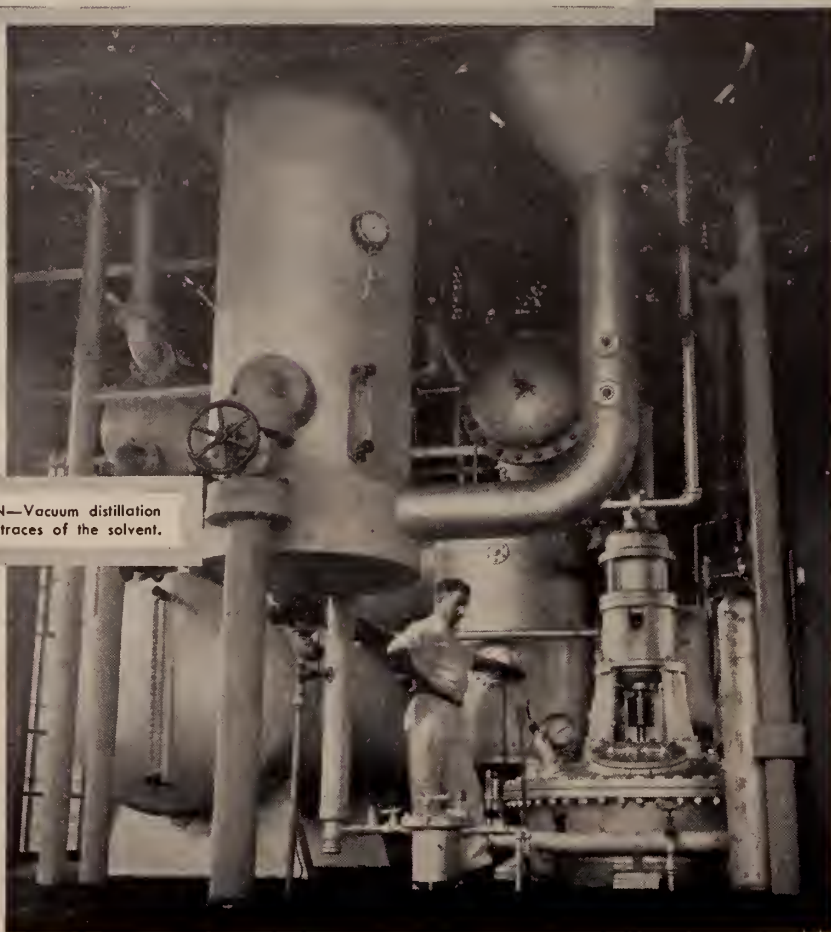


3 EXTRACTION—The vitamin-containing fraction is extracted by a process which removes the oil and leaves a portion containing the natural vitamins in unaltered form.

4 PURIFICATION—Vacuum distillation removes all traces of the solvent.



5 CONTROL—The final product is assayed and standardized to assure uniform potency.



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Daily blood counts and urinalysis should be made for evidence of hemolytic anemia, leukopenia and hematuria. One of the most serious complications that should be looked for is interference with kidney function.

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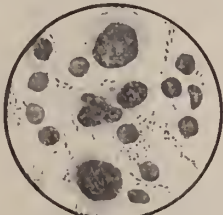
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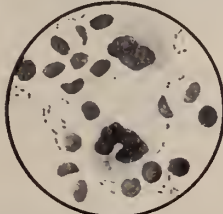
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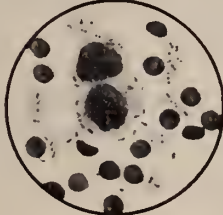
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(Based on bone marrow culture studies of Bullowa and Osgood—
Jour. Mich. State Med. Soc., July, 1939, Vol. 38, No. 7, p. 563)

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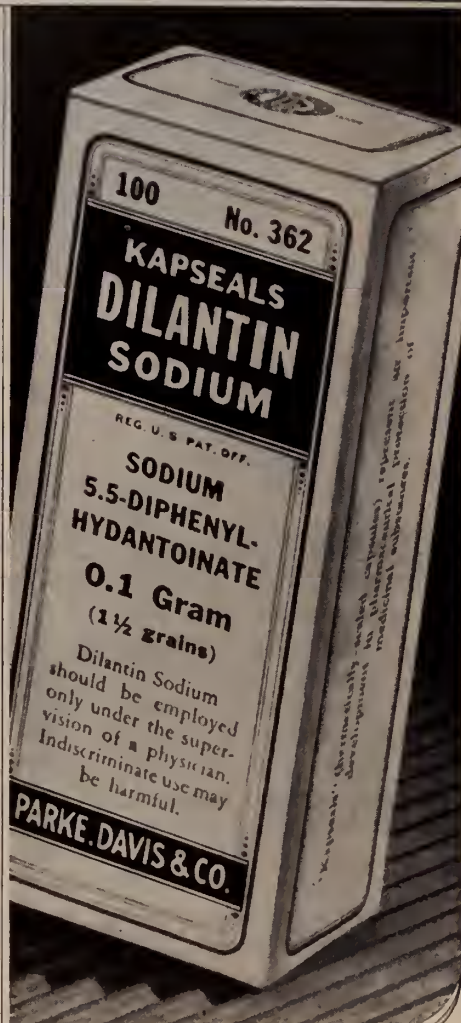
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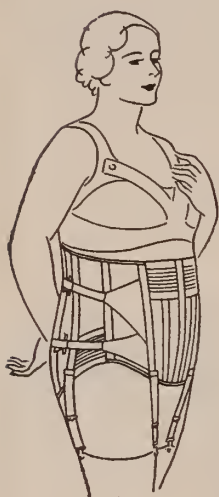
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PUBLISHED MONTHLY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



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EDITORIAL

Reports of Committees

The first editorial in the Journal of July, 1939, was entitled "Schedule of Committee Meetings"; and was an announcement of a plan by which each *advisory committee* should adopt a program of objectives and actions, and should report it to its *sub-committee*, which in turn should report it to the Welfare Committee, which supervises the standards and extensions of private practice.

It is most gratifying that the plan was carried out with one hundred per cent efficiency, as is shown by the reports which fill pages 669-679 of this Journal.

These reports justify the wisdom of Drs. Eagleton, Harvey, and other far-seeing prophets who established the Welfare Committee at the Annual Meeting of The Medical Society of New Jersey on June 25, 1919. (Journal, November, 1937, page 687.) The functions of the newly organized committee were those which it still exercises; but its field of service grew apace, and sub-committees were assigned to special duties; and later advisory committees were assigned to particular problems, until the present efficient, unified system of four sub-committees and twenty advisory committees was established.

This form of organization is unique among medical societies, and has been the means of raising the efficiency of The Medical Society of New Jersey to commanding heights. Moreover it has inspired the larger county societies to establish similar systems of organization.

The system of organization is entirely democratic. The initiative for extending any field of service lies with the advisory committee; which reports its plans to its sub-committee; which in turn reports it to the Welfare Committee. Finally the Welfare Committee reports to the House of Delegates, or to the Board of Trustees, which assign a definite budget to each division and committee according to its projected program.

Read the announcements of the several committees, and familiarize yourself with the outstanding progress in the several fields of activity of The Medical Society of New Jersey and its component county societies. The physicians of New Jersey are fortunate in establishing their own great system of coördinated medical practice, and the people are equally fortunate in having public-spirited medical leaders.

The New Jersey Medical Care Administration

The Medical Society of New Jersey is the official interpreter of the high ideals of the practicing physicians of the State. During the 173 years since its founding on July 23, 1766, the Society has watched the progress of medical knowledge, and guided its application to the needs of people.

The members of this Society believe it to be their duty now, as it always has been, to make suggestions to legislators and citizens regarding their necessary coöperation in adapting modern medical knowledge to the present-day needs of the people. It is in this spirit that the physicians of New Jersey are now attempting to solve the social and economic problems connected with the conservation of the health of the people. The functions involved in the determination and solution of these problems are two-fold:

1. To analyze the medical needs of the people.
2. To suggest practical ways and means for supplying the needs which are discovered.

THE COMMITTEE

The development of these two functions was assigned by the House of Delegates to a committee composed of the New Jersey Delegates to the American Medical Association, who are peculiarly well-fitted for the task for two reasons:

1. The eight Delegates and Alternates are physicians of broad experience in all phases of medical administration over a period of years, five being Fellows (Past Presidents) of the State Society.
2. Five of the Delegates have already had a broad experience as Delegates to the A. M. A. in former years; and all will come in contact with the delegations from all the other State Societies, and will therefore be assured of a respectful hearing in the national council.

FACTORS IN HEALTH CONSERVATION

The committee has tacitly assumed that the conservation of the health of the people depends on five major factors:

1. *Medical advice* by practicing physicians.

2. *Personal Hygiene*.—The precautions taken by the people themselves, such as cleanliness, diet, etc.

3. *Sanitation*.—Government control of environmental conditions, such as water supplies, sewage disposal, milk inspection, highway safety, etc.

4. *Education*, by means of public schools, the press, the radio, lectures, demonstrations, etc.

5. *Economics*, or the financial means for obtaining the necessities, the comforts, and the enjoyments which are requisite for healthful living.

The first four factors are now carried on effectively in accordance with accepted standards. The fifth,—that of *medical economics*,—is the subject of the major part of the report of the committee.

Using the facilities of the Executive Office of the State Society, the committee has prepared a comprehensive report on the two functions that were assigned to it; and has submitted its findings and recommendations to the Board of Trustees for consideration and approval.

1. FIRST FUNCTION OF THE COMMITTEE—TO SURVEY THE MEDICAL NEEDS OF THE PEOPLE

The committee refers specifically to two surveys which have already been made:

1. "The New Jersey Survey of the Need and Supply of Medical Care", sponsored by the A. M. A., and executed by The Medical Society of New Jersey.

2. That by Governor Moore's "Conference on Health and Welfare in New Jersey".

Among the basis for these surveys are the economic reports which are on file in the offices of the several departments of the State Governments, such as:

Income tax returns.
Workmen's Compensation.
Welfare Relief.
Hospital reports.
Emergency Relief reports.

The reports and surveys clearly indicate the scope and importance of the economic prob-

lems involved in the distribution of medical services.

Two facts are accepted:

1. Practically every family has need of medical services at some time during the year.

2. The amount and kind of medical service which any given family or individual will need cannot be predicted with certainty. However, it is possible to divide the people into three groups according to their individual means for providing medical services for themselves and their families:

1. The well-to-do.

2. Those of low incomes,—for example those with annual incomes above one thousand dollars.

3. Those with incomes below \$1000, or no income at all.

Those in the well-to-do class are able to secure abundant medical service for themselves and their families, and are therefore not to be considered, except as contributors of the taxes levied for the benefit of the two other groups.

Those in the second group are able to provide the necessities of life and some of its luxuries, so long as they or the members of their families are in good health; but they cannot meet the expense of prolonged illness, especially when the wage earner is incapacitated. For the benefit of this group—sometimes called "Low-wage group"—The Medical Society of New Jersey is earnestly endeavoring to develop the "Medical Service Plan" as a system of insurance at a low rate of advance payment.

Those in the third group,—with incomes of less than \$1000,—are barely able to provide the necessities of life under ordinary conditions, and are unable to pay any part of the expense of medical care, except the most simple.

The well-to-do are subjected to all sorts of inquisitions into their financial affairs. In all

probability, it will be necessary to impose the same kind of inquisition upon those who are classed in groups two and three. How to do it with any degree of satisfaction is still a problem upon whose solution committees of the Medical Societies throughout the nation are earnestly working.

2. SECOND FUNCTION OF THE COMMITTEE—TO SUGGEST A SOLUTION OF THE PROBLEM

To state a problem clearly and accurately is a long step toward its solution. New Jersey is fortunate in having had its experience with the Emergency Relief Administration over a period of three years, beginning with the year 1933. The medical features of this project were originated by the Medical Society of the State and those of its several counties; and the bills for medical services were audited by volunteer committees of physicians who served without pay, or even their expenses. The details of its cost and the methods of its management are matters of public record, and are summarized in the report of the present committee of The Medical Society of New Jersey.

ADMINISTRATIVE MEASURES

The second half of the report of the Committee of Delegates deals with specific plans for setting up and administering the services of medical relief; and with estimates of their probable costs. To summarize the plans in the present stage of their development is difficult, because they are already extremely concise, and clear, but are subject to changes in their details. The proposed plans are not the work of theorists; but are based on actual experiences under the E. R. A., compensation of injured workmen, and other forms of medical relief which have already been tested over a period of time sufficient to indicate the proper lines of their further development in the near future.

How to Behave When Sick

A thirteen-year-old boy, parked in a neighbor's house while his parents were away for the evening, was bored because he had nothing to do. He was told to write something on "How to behave when sick"; and in response he produced the following composition, which is as good as most doctors could do.

I have been asked to write a composition on this topic. I know just as much about it as a hen knows how to "shoot the sun".

In my mind there are three important words which answer the topic—patience, obedience, and occupation.

First, *patience*. If one who is sick is not patient, he will make himself much worse. Most likely in time his trouble will become serious, unless someone is there who is patient to calm him. If people were more patient, doctors would not be called on so many foolish errands.

Secondly, *obedience*. If one is ever to get well, he must be obedient. No backing out of taking pills, etc. When a doctor gives an order, you must carry it out, if you ever expect to get well.

Last, but not least, *occupation*. In my mind, this is the most important factor. As you

know, worrying is about the worst thing for curing any sickness. If you expect to overcome this fault, you must find something interesting to occupy your time. Some people when they are sick just stay in bed and wait for results. Of course they do more harm than good because the only thing they have to think about is how bad off they are. But not all people are that way. I have a friend who, when he was sick, started the hobby of beadwork. Now that he is well, he has established a small business of selling his beaded bracelets, belts, necklaces, etc. So, you see, some people gain by being sick in establishing maybe a life-saving hobby, or perhaps a vocation.

So, in conclusion,—whenever you are sick, being patient, obeying your doctor's orders, and finding something to distract your mind from your own condition, will soon get you well.

Fall Clinical Conference

As this Journal goes to press, the preparations for the Second Fall Clinical Conference of The Medical Society of New Jersey are completed. The object of the Conference is to provide facilities for demonstrations and consultations in all branches of the practice of scientific medicine. This is necessary because nearly all the available time of the Annual Meeting is devoted to administrative medicine, and discussions on the public relations of physicians.

The Fall Conference held last year in Newark was a pioneer effort in holding a two-day session on the subject of scientific medicine exclusively, and twenty-five per cent of the practicing physicians of the State accepted the opportunity to observe the inner workings of the hospitals and clinics of Essex County.

This year the opportunities for observation and instruction will be equally broad. Ten hospitals will open their wards and operating rooms to inspection by the visiting doctors, while 165 physicians, or one-half of the members of the Hudson County Medical Society, are listed among the speakers and demonstrators.

A tentative program of the Conference was printed in the Journal of October, pages 616 and 617; and a copy of the detailed program was mailed to each member of the State Society during the last week of October.

The final event of the Conference will be a social dinner, at which Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, will be the guest speaker.

ORIGINAL ARTICLES

X-RAY LOCALIZATION OF INTRAOCULAR FOREIGN BODIES FROM
THE VIEWPOINT OF THE OPHTHALMOLOGIST

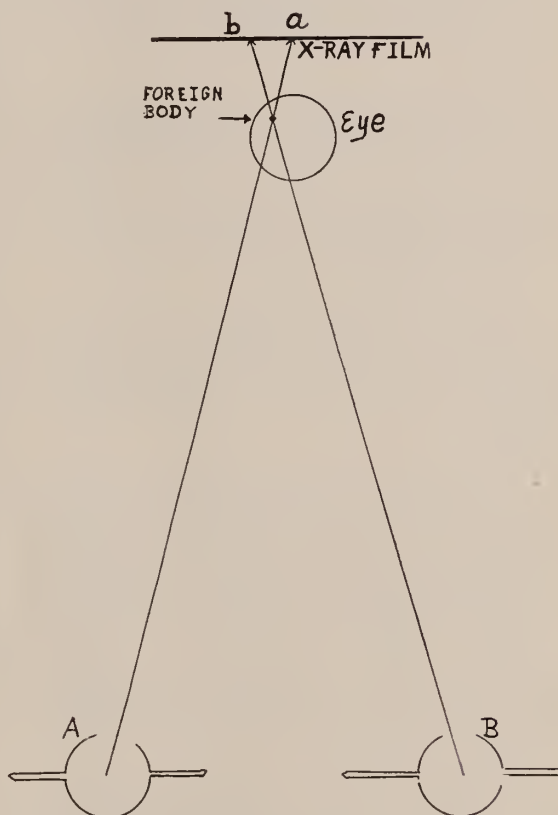
By A. RUSSELL SHERMAN, M.D., Newark, N. J.

Read before the Combined Sections on the Eye, Ear, Nose, and Throat, and Radiology at the Annual Meeting of The Medical Society of New Jersey, June 6, 1939.

Compared with its diagnostic and therapeutic importance to the practitioner in many other branches of medicine, roentgenology plays a relatively minor rôle in the practice of the ophthalmologist. He occasionally sees a patient who requires an x-ray examination of the orbit, or perhaps treatment of a growth of or near the eye; but to the average ophthalmologist, the localization of foreign bodies is the most important use of the x-ray.

Several principles have been employed to localize a radio-opaque object in or near the eye, but the one in common use is that of two exposures, with a shifting of the tube between exposures, so as to alter the direction of the rays, and make use of the parallactic displacement of the shadows in determining the position of the foreign body.

One or more metallic markers near the apex of the cornea are used. The marker is located a known and fixed distance from the cornea; and its shadow, on the film, serves as a point from which measurements are taken. The exposures are made with the film adjacent to the patient's face on the same side as the eye which is being examined, and the tube on the opposite side, about two feet from the film. One can measure directly on the film the distance of the foreign body from the marker in one plane; and, if in one of the exposures the direction of the rays has been perpendicular to the film and parallel with the horizontal meridian of the eye, in a second plane as well. Its position in the remaining plane or planes is determined by the displacement of the shadow on the film when the direction of the rays is changed by shifting the tube. The simple diagram shows how this takes place. Because of



Method of plotting the location of a foreign body in the eye by the use of x-rays.

the manner in which the apparatus was set up, the directions of the rays casting the shadows a and b, from positions A and B of the tube are known, or can be easily calculated, and the point where they intersect indicates the position of the foreign body in two dimensions. Although there are several methods of plotting the location of the foreign body, they are all based on this principle.

This method, as perfected by Sweet and by Dixon, is extremely accurate, and theoretically,

except for one unavoidable source of error, apparently perfect. The unavoidable possible error results from the fact that all eyeballs are not of equal size, whereas an average size must be assumed in making the examination. This is of importance in those cases where the film shows the foreign body lying within one or two millimeters of the sclera, so that it could be just within or without the globe. In such cases examinations made with the eye rotated in the proper directions will often be helpful, since a foreign body lying inside the eye near the sclera will cast a shifting shadow on the film.

In spite of the accuracy of a properly made x-ray examination, one can find in a group of cases a few in which the ophthalmologist received misleading x-ray reports, especially negative reports when a foreign body was subsequently shown to be present.

Of ninety-five records in our * office of patients with foreign bodies deep in the eye (behind the iris), at least one negative x-ray report appears in eleven. These will be briefly described.

1. J. C. In August, 1936, his right eye was struck by a particle of steel while a fellow workman was using a hammer. When examined on September 27, 1937, the eye showed a faint perforating scar in the temporal half of the cornea, with a perforation in the underlying iris. The lens was cataractous, and siderosis was present. An x-ray examination was negative. Another one the next day, using a dental film on the nasal side of the globe, with the x-ray tube in a position to avoid some of the bony structures, showed a foreign body $1 \times \frac{1}{4}$ mm. in the anterior part of the eye.

2. K. E. He was first examined September 7, 1933. Three months before, something had struck his right upper lid as he was hitting a piece of steel with a hammer. X-ray at that time had been negative. Examination of the eye was negative except for a cloud of fine vitreous opacities, and a spot of choroiditis in the temporal periphery and another in the inferior periphery. He was seen again May 21, 1934, and stated that another ophthalmologist had received a positive x-ray report a few months after our first examination.

3. E. N. In August, 1937, something hit his left eye as he was striking a bolt with a hammer. October 14, 1938, the eye showed a faint perforating scar of the cornea, siderosis, and a cataract. An x-ray examination was reported as being negative. A second one showed a small foreign body. It was

removed and found to be one by one millimeter in size.

4. C. W. was first seen July 6, 1937, with a small perforating scar in the cornea, and a partial cataract below it. A month before, something had struck his right eye, and after a negative x-ray examination he had been treated for an abrasion of the cornea. An x-ray examination July 7, 1937, showed a foreign body one by one millimeter in the anterior portion of the eye.

5. A. Z. On June 17, 1927, his left eye was struck by a flying chip of steel. When he was seen the next day there was a small corneal wound with a defect in the underlying iris. An x-ray examination was negative. A second x-ray showed a foreign body one mm. long.

6. A. T. On November, 1930, while striking a steel drum with a hammer he had felt something hit his left eye. An x-ray examination at that time was said to have been negative. On examination February 5, 1931, the eye showed a perforating scar of the cornea, and a partial cataract. Another x-ray February 12, 1931, was positive for foreign body.

7. C. B. was first seen December 19, 1928, with the scar of a recent wound in the sclera two mm. nasal to the limbus of the right eye at the four o'clock position, and some blood in the vitreous. A month before, something had struck the eye while he was splitting wood. An x-ray examination at that time had been negative. One made December 20, 1928, was positive. The foreign body after removal was found to be one by one and a half mm. in size.

8. G. K. was seen June 20, 1930, while under treatment of another ophthalmologist. His right eye had been struck by pieces of steel from a breaking die January 6, 1930, and three or four x-ray examinations had been negative. There was a perforating scar in the upper portion of the cornea, a defect in the underlying iris, which showed some brownish discoloration, and the anterior lens capsule had brownish powdery deposits on its surface. In the extreme upper periphery of the fundus was a white scar with much pigment around it.

9. E. A. was seen August 22, 1930, while under the treatment of another ophthalmologist. June 14, 1930, something from an emery wheel had struck his left eye. There was a recent perforating scar of the cornea, also a brownish punctate stain on the capsule of the lens, which was opaque. An x-ray August 1, 1930, was said to have been negative. December 22, 1931, he was seen again with a severe uveitis and secondary glaucoma of six weeks' duration for which enucleation was performed. A second x-ray had been taken after his first visit and reported negative, but a third one of the enucleated eye was positive, and the foreign body, one by one mm. was found in the posterior part of the lens.

10. C. B. was seen October 19, 1922, one day after having been struck in the left eye by a particle of steel from a hammer. Although an x-ray report was negative, a foreign body could be seen with the ophthalmoscope in the anterior part of the vitreous.

* Elbert S. Sherman, A. Russell Sherman.

11. H. B. This patient did not have an intraocular foreign body, but the site of the injury was such as to make an intraocular foreign body a possibility. He had been striking a chisel with a hammer on April 16, 1931, and had felt something hit his right eye. An x-ray examination had been negative. There was a small dark wound at the limbus nasally, but no indication of intraocular disturbance. On May 11, 1931, when he was seen again, the dark spot was still present, and by probing with the tip of a knife, was found to be a foreign body measuring one by two m.m.

It will be noted that the foreign body in these cases usually was not more than one m.m. in length. One can readily understand, therefore, how, in the midst of bone shadows from the skull, it could be missed even by a roentgenologist with considerable experience in such work; and how much more frequently by one less experienced.

When an x-ray examination has shown the presence of a foreign body and a localization has been made, there is seldom an opportunity of verifying the accuracy of the localizing report. That it cannot be accepted blindly is shown by the following case which was examined through the courtesy of Dr. Wallace Pyle:

F. L. was seen August 10, 1937. There was no history of injury, but in the left eye, which had been inflamed off and on for a year, there was a small, linear perforating scar of the cornea, just inside the limbus at the four o'clock position; behind it, and projecting from the anterior surface of the iris was a round, dark mass two mm. in diameter. The report of an x-ray examination made five days before placed the foreign body three mm. below, three mm. back of, and three mm. nasal to the apex of the cornea.

Mistakes by either the patient or the operator may cause errors of this sort. A certain position of the marker relative to the cornea, and certain directions of the rays are assumed in determining the position of the foreign body. Hence the most meticulous care is required in the adjustment of the apparatus if the actual working conditions under which the exposure is made are to correspond with those assumed in the plotting. Even if the operator's work has been flawless, movement by the patient of his eye remains a factor to introduce error; and unless the eye can be kept under observation throughout the exposure, this possibility is always a likely one.

X-ray examinations, in general, like other laboratory procedures, are sometimes essential in arriving at the best possible diagnosis, and are also sometimes subject to misinterpretation. Examination for intraocular foreign bodies is no exception. The ophthalmologist whose practice includes patients with intraocular foreign bodies would feel the loss of this aid to diagnosis, but he would still be able to make correct diagnoses and give suitable treatment in a large percentage of his cases. A study was made of the records of eighty-seven patients from whose eyes intraocular foreign bodies had been removed. None was in the anterior chamber or iris, but all lay posterior to the iris. It was found that forty-one foreign bodies were removed without an x-ray examination. In twenty-one cases the foreign body was seen with the ophthalmoscope.

This latter figure would indicate that in almost 25 per cent of the cases a foreign body was seen with the ophthalmoscope.

This is a sufficiently large percentage to make thorough clinical examination well worth while, if only from the standpoint of the satisfaction derived from a complete and accurate diagnosis. Moreover, if the foreign body can be seen in or near the lens, or lying on the retina, the localization is likely to be more dependable than one obtained by the most accurate x-ray examination. Thorough dilatation of the pupil and examination with the patient in the supine position are very helpful. If, after a thorough examination, there is still doubt about the presence of a foreign body, x-ray examination should always, of course, be made; and in cases of recent injury, where prompt removal is very important, the x-ray report should be received with the least possible delay.

It is the ophthalmologist, however, not the roentgenologist, who is in a position to see the faint corneal scar, the slight iris defect, or the small lens opacity suggesting perforation by a foreign body, which is perhaps so small that it is not visible on the ordinary film. He will do well to choose a roentgenologist whose work he considers above suspicion; and having chosen him, to be still moderately suspicious of his reports, especially negative ones.

SUMMARY AND CONCLUSIONS

1. The usual method of x-raying eyes for intraocular foreign bodies is briefly described.

2. The records of ninety-five patients with foreign bodies in the posterior segment of the eye are discussed in regard to:

a. Foreign bodies overlooked in x-ray examinations.

b. Foreign bodies incorrectly localized.

c. Foreign bodies removed without x-ray examination.

d. Foreign bodies visible with the ophthalmoscope.

3. It is concluded that x-ray examination of the eye for foreign bodies is not infallible, and that reports of such examinations are not to be accepted blindly but only in connection with all other findings.

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SURGERY OF THE RECTUM AND COLON

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Read before the Section on Surgery at the Annual Meeting of The Medical Society of New Jersey,
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The prevalence of serious lesions of the rectum and the colon is an impressive fact which should be more generally appreciated by the profession at large. The frequent incidence of acute and chronic conditions in this region makes it imperative that one be constantly on the alert to the need of early and accurate estimate of the cause of the symptoms reported in every case coming under observation. In early recognition lies the hope of more effective control. This particularly applies to the incidence of *malignancy*, which subject is the main theme for our consideration.

CANCER OF THE RECTUM

Cancer of the rectum occurs most frequently in patients over forty years of age. There are authenticated cases reported in ages 15-30. These usually occur as single lesions, but the possibility of multiple lesions should always be borne in mind.

Patients manifesting evidence of lesions of the rectum or colon first seek aid from the family physician. The care and thoroughness which attends the initial examination may determine recognition of the correct diagnosis at a time when early institution of adequate treatment offers a more favorable prognosis.

Proper estimate should be accorded the clinical history. The assumption that rectal bleeding is due to the presence of hemorrhoids, as usually stated by the patient, should be care-

fully verified or disproved by a painstaking examination. This involves inspection, digital exploration, proctoscopic visualization with proper illumination and equipment, sigmoidoscopic search. X-ray study, after barium enema and contrast media may supply valuable data when properly interpreted. Most of the rectal lesions can be reached by the examining finger.

All suspicious areas should be subjected to a biopsy which should include the deeper structures, as well as the projecting portions of tissue in which the transition from the benign to malignant tissue may be not apparent.

There is no disease in which a correct diagnosis may be made earlier or more accurately. It is an appalling fact that these cases are often not seen by the surgeon until well advanced. It is true that patients neglect to seek advice early. It is also a fact that they are frequently sent on their way with ointments and suppositories without having had an adequate examination.

Patients presenting unmistakable evidence of moderately advanced cancer of the rectum are frequently advised that surgery would be of no avail; whereas with the perfection of numerous technical procedures, much relief of unnecessary suffering and prolongation of life may be accomplished. These subjects, without any treatment, are a long time dying.

Examination may be made more comfort-

ably in Sims position, which permits extensive digital exploration. The knee-chest position allows more satisfactory proctosigmoidoscopy; the lithotomy position is limited in its scope. Inspection may demonstrate an ulcerated nodule, with irregular raised border, or an annular type with a punched-out margin of its lumen. Usually the diagnosis is apparent on inspection, and biopsy will confirm it.

Up to the present time, surgery offers the greatest assurance of prolonging life and increasing comfort, as long as life does last. This is exemplified particularly in cases of obstruction where a colostomy may give prolonged relief from an intolerable condition.

Twelve per cent of all cases of carcinoma occur in the intestinal tract, of which 70 per cent are in the rectum.

Daniel Jones,¹ of Massachusetts General Hospital, states that 75 per cent of the cases seen by him have been treated for hemorrhoids; and 83 per cent of the cases presented for treatment by Lockhart-Mummery² have already reached a stage too advanced for removal. The percentage of operability in the average hospital cases range from 50 to 60 per cent.

COLOSTOMY

Unless there be definite evidence of extensive metastasis, surgery should be advised in all of these cases, for if exploration demonstrates extensive liver and mesenteric involvement, a simple colostomy is performed. In addition to relieving obstruction, colostomy adds greatly to the comfort of these patients. The mortality rate of colostomy is low, except in the poor risks, in which it may be around ten per cent. By assuring a definite improvement in the immediate condition and general comfort of the patient, it may also prolong the life of the individual.

The proper care of the colostomy is important. A low residue constipating diet is essential; irrigation of the lower tumor-bearing segment once or twice a week adds to their comfort. Various types of bags are employed. Several of my patients have had greater comfort in the wearing of a combination pad, changing as required. A simple abdominal belt

holds this in position, the soiled dressing is discarded, the patient is free from any objectionable odor of the colostomy bag, and is relieved of the necessity of its care.

Until about 1910, the usual operative procedure for malignancy of the rectum was the establishment of a permanent colostomy.

In 1912, W. J. Mayo⁷ described a method of excision of the growth, with the establishment of a permanent colostomy. The bowel was excised for a distance of two inches below the growth, the remaining portion being invaginated, and the peritoneal flaps sutured about the stump. If great care be employed, this may be done without drainage of the abdominal cavity. It has the advantage of less shock than that accompanying the removal of the rectum, the patient has the satisfaction of having the growth removed, and makes a quicker convalescence. It is applicable to only a limited group of cases, however.

A more recent modification in which resection of the lower colon with preservation of the rectum is accomplished by Dixon¹² of the Mayo's Clinic. A colonic stoma is first established in the transverse or descending colon as a first stage procedure. Several weeks later the abdomen is explored through a low mid-line incision. The pelvic colon is then mobilized by freeing the attachments on both sides of the intestine. The vessels are ligated, and the sigmoid is radically removed. The bowel is amputated in the upper part of the rectum, and an end-to-end anastomosis is made between the lower part of the colon and the rectum. Two or three weeks later the colonic stoma is closed. Dixon reports ninety cases with a mortality of ten per cent.

RECTO-SIGMOID CANCER

In 1908 and 1912 Miles^{5,6} presented papers on the radical treatment of carcinoma of the recto-sigmoid, which are comprehensive classics and have supplied the basis of the adoption of the modern radical one and two-stage procedures now being employed to a great extent by the surgeons of this country. Miles gave consideration to the important relationship of the extension of malignancy by the distribution of the pelvic lymphatics. His

method consisted in establishing a permanent colostomy, together with the radical excision of the recto-sigmoid and mesenteric glands by a one or two-stage procedure. This original Miles operation, together with various modifications of individual operators, is the method of election in many cases today. If the method is employed as a one-stage procedure in unsuitable cases, the mortality is unjustifiably high. In performing the two-stage method we have found it desirable to excise the redundant portion of the lower segment before closing over the pelvic peritoneal flaps. This prevents necrosis of the loop to be removed later by rectal excision.

Because of the degree of advancement of the malignancy in such a large percentage of the cases presented for surgery, some form of two-stage procedure will probably give better results in the hands of the average surgeon.

Lahey's⁸ two-stage method offers a logical safe technic and has proven satisfactory in our experience. The primary operation consists of an exploration through a left rectus incision, determining the location and extent of the lesion, the existence of metastasis, the condition of the liver, et cetera; and the establishment of a permanent colostomy with a loop of the sigmoid, the implantation of the upper end of the lower segment of the recto-sigmoid, containing the neoplasm, in a suprapubic mid-line incision. The superior hemorrhoidal vessels are identified and carefully preserved. The division of the lower vessels and the mesentery is then carried out, mobilizing the lower segment, the outer leaf of the peritoneum being divided previously.

An important point is the closure of the lumbar gutter by suturing the parietal peritoneum in a vertical direction to the bowel segment, and then suturing the omentum to the median meso-colon above the location of the superior hemorrhoidal vessels and along the cut mesentery of the distal loop up to the attachment to the peritoneum beneath the stab wound. This prevents the small bowel getting down into the left pelvis.

The lower segment is irrigated daily, a more favorable condition being obtained for the removal at the second stage two weeks later. In

the interval, attention is given to the improvement of the patient's general physical condition by all the usual methods, including intravenous administration of glucose and saline, and where indicated, blood transfusions.

At the second stage the abdominal cavity is opened above the implanted lower segment, the opening of which has been previously sutured, the section of the bowel is mobilized, the superior hemorrhoidal vessel identified and ligated, and the bowel freed down to the tip of the coccyx and the segment placed down in the pelvis. If the loop is too redundant, a portion may be removed between clamps and the remainder pushed down. The pelvic peritoneum is approximated, closing over the cavity.

The perineal resection is then performed as in the similar procedure of Miles' operation. This method leaves the patient with an abdominal colostomy and entails the opening of the peritoneal cavity a second time for the final stage. In the hands of such master surgeons as Lahey and Cattell, the operative mortality as reported in 1935 was around ten per cent. This has since been reduced in the later cases operated in that clinic.

During the past few years there has been an increasing trend to the performance of a one-stage abdominal perineal resection, in favorable cases. If patients come under observation sufficiently early, with fair general condition and are not too obese, if adequate preliminary preparation be accorded, a single stage resection may be performed by any experienced surgeon who has mastered the technic of one of the recognized methods. Unless these conditions are met, a permanent colostomy with or without posterior resection may give a more favorable result.

The one-stage abdomino-perineal resection, with the establishment of a perineal anus, as advocated by Wayne Babcock,⁹ has proven very successful in his skilled hands. We have had satisfactory experience in two of three cases done after this method. The first case was not a suitable one for the method, and the patient died after forty-eight hours from surgical shock. It was an error of judgment to have attempted the one-stage procedure in an unfavorable case. The other two cases made satis-

factory recoveries and are well today; one a year, and the last one seven months after the operation.

The latter patient, a woman thirty-eight years of age, first seen in October, 1938, with a history of pain and rectal bleeding since March, was found to have an ulcerated lesion of the recto-sigmoid extending around three-quarters of the circumference of the lumen of the bowel—a firm nodular carcinoma. She was an intelligent person, aware of her condition, and stated that she would prefer death to having an abdominal colostomy. After suitable preparation, a one-stage abdomino-perineal resection was performed on November 1st after the method of Babcock. She has gained twenty pounds in weight, and is living a normal and comfortable existence, and enjoys the care of her four-year-old twins. She takes daily enemas and adheres to a low residue, high caloric diet.

The advantages of this method are that it enables the performance of a radical and extensive perineal resection in one stage without undue shock; that the bowel is not opened until the completion of the operation, thereby lessening the likelihood of contamination of the peritoneal cavity; a small perineal wound with more rapid closure; and the establishment of a perineal anus which is greatly preferred by most patients. Some contraction of the anal opening from cicatricial tissue occurs in these cases. This may be controlled by routine employment of dilators.

Rankin,¹³ whose experience at the Mayo's Clinic has been so comprehensive, describes a method of performing the two-stage resection by opening through a low mid line incision, dividing the mesentery preserving the essential blood supply, grasping the proximal portion of the sigmoid by Pahr clamps introduced through a small intramuscular incision into the lower left quadrant, dividing the segment between clamps by cautery withdrawing the proximal loop for the establishing of a permanent colostomy. The end of the lower segment is turned in and dropped back into the peritoneal cavity.

At the second stage the anus and rectum are dissected free, and the coccyx removed. The liberated segment is covered by a rubber glove and pushed into the hollow of the sacrum, the perineal wound being then closed. The abdomen is then opened, the lower segment of the sigmoid dissected free, the entire mass

being removed, including the lower segment previously freed being removed through the abdomen; the pelvis being covered by peritoneal flaps. A gauze pack is then introduced through the posterior wound into the hollow of the sacrum.

T. E. Jones,¹⁴ of Cleveland, advocates a one-stage abdomino-perineal resection for properly prepared patients. The permanent colostomy is left in the mid line or left McBurney incision. The lower segment of the recto-sigmoid containing the neoplasm is mobilized after careful ligation of the vessels. The pelvic cavity is covered over by peritoneal flaps, and the abdominal wound is closed. This is followed by a posterior resection.

Lynch,¹⁵ of New York, is an advocate of posterior resection by the perineo-abdomino-perineal method. He reports a large series of cases, and advises surgical intervention in many of the cases which are seemingly unfavorable.

Coller and Ransom¹¹ report the results of their study of 270 patients with carcinoma of the rectum and sigmoid, 224 of whom were given treatment. Fifty-one per cent of their cases were unsuitable for radical treatment because of the far advancement of the lesion or by the existence of associated disease. The abdomino-perineal operation was done in two stages on twenty-seven patients, and in one stage on seventy-two patients, their experience being that the second stage frequently proved more difficult than the one stage because of the existence of adhesions from the primary operation. Their conclusions are that most patients can be operated upon as safely in one stage as with the multiple stage operations, provided that the patients have received proper preparation. All of the patients reported in their series had had vaccination with Bactrogen as developed by Steinberg, and they feel that it is a distinct advantage in lessening the incidence of peritonitis. The use of amniotic fluid as pre-operative preparation for peritoneum has been recommended by Young and Marks.¹⁶

For lesions occurring in the sigmoid which can be mobilized sufficiently to be brought outside the peritoneal cavity, the Mikulicz operation is very suitable. It can be performed ex-

peditionously and safely even in the bad risk cases. The neoplasm together with sufficient upper proximal and lower distal colon, the two vertical limbs of which have been sutured together, are exteriorized. Strong Pahr clamps are applied to both portions of the bowel. The left rectus abdominal incision, through which an exploration to determine the presence of metastasis in the mesenteric glands or liver has been carried out, is closed around the extruded loop of bowel. The growth and the loop of bowel external to the forceps is excised by cautery after two or three days. In some cases we have excised the entire mass immediately on completion of the operation. Usually the clamp at the upper proximal limb should be left on for forty-eight to seventy-two hours,—the longer the better. If the upper portion is greatly distended as a result of obstruction, the wall of the protruding bowel beneath the clamp may be punctured by the cautery, and a catheter inserted into the lumen and fastened *insitu*, affording a means of escape of the gas.

In two cases we have introduced a rectal tube in the open end of the upper segment at the time of operation, thereby decompressing the bowel immediately. If the tumor mass is necrotic, we prefer to excise the entire mass at the time of operation, thus eliminating a troublesome foul-smelling mass from the field. In ten to twelve days after the first procedure the raphe consisting of the approximated limbs are treated in one of two ways. Either a strong, heavy, crushing forcep three to four inches in length is applied to the dividing segment gradually being closed completely in twenty-four to forty-eight hours, thus destroying this partition; or this segment is divided by sharp dissection between long Kocher clamps, both lateral margins being sutured with silk. This creates a single cavity of increased space of the double-barrel segments.

We have recently employed this method in two cases with good results. The Mikulicz method, or one of the several modifications, is also applicable to lesions of the other portions of the colon, as well as conditions involving the ileocecal region resulting from acute intestinal obstruction in which massive resections are imperative.

In many instances it has proven a life-saving procedure in cases where an anastomosis could not be tolerated.

Extraperitoneal implantation of the colon with a one-stage resection in which the approach to the peritoneal cavity is made laterally over the previously localized neoplasm is described by Harsha,¹⁷ of Chicago. The tumor is resected, both ends of the bowel closed by pursestring stitch, and a lateral anastomosis performed. The peritoneum is closed about the extruded anastomosis. The abdominal wall is closed, with a stab wound drain inserted in the flank.

CHOICE OF OPERATION

Reference has been made to the several authorities whose main scheme of technical procedures are similar, all of which are designed for a complete excision of the diseased portion of bowel and its accompanying lymphatics.

There is today a more extensive employment of the radical one-stage procedure, for by the free employment of blood transfusion and other supportive measures it is possible, in many instances, to complete both the abdominal and perineal portions of the operation at one stage without undue shock.

However, the keynote of success in intestinal surgery as elsewhere is proper preparation of the patient, and the determination of the technical procedure to be employed in the individual case at hand.

For lesions of the ascending colon, ileocolostomy with a removal of the growth at the time of the original operation or at the second stage has given the most satisfactory results in our experience. The anastomosis should be completed; and if conditions are then favorable, the excision of the involved loop is done at once. If not, a second stage is carried out at a later date. Where the growth is situated in the transverse and splenic flexures, the preliminary cecostomy aids materially in improving the condition of these subjects. The resection with end-to-end or lateral anastomosis is performed, in most instances, the large calibre of the bowel permitting a satisfactory end-to-end approximation.

In bad cases where time is an important element, the use of the Murphy button in end-to-

side anastomosis has been recommended by Mayo.¹⁸ This procedure is of great value in an emergency, can be done expeditiously. The small lumen of the Murphy button is sufficient to allow transmission of gas and fluid feces promptly.

In the last two years we have had good results with three cases of carcinoma of the transverse colon in which a preliminary cecostomy was followed by a resection of the neoplasm with sufficient adjacent bowel and an end-to-end anastomosis performed. The particular procedure to be done in each instance should be based upon the local condition and the patient's general condition, the skill and judgment of the operator guiding the procedure.

EXPERIENCE IN THE ORANGE MEMORIAL HOSPITAL

In the period from 1928 to 1938 there have been ninety cases of cancer of the rectum and colon treated by the several services in the Orange Memorial Hospital. Of the ninety cases treated, forty-four had colostomies alone, because of the advanced condition of the lesion found, or because of the poor general condition of the subjects. Two-stage procedures were performed in twenty-one cases. Of these nineteen were done by the Miles method, and two by the Lahey method. In one of these the first of the two-stage procedures alone was performed. Three cases of the ninety were treated by the one-stage method of Babcock; four were treated by radium therapy; and the

remaining eleven were treated by colostomy alone.

The hospital mortality of all of these cases was 31 per cent. This should be, and is being, greatly reduced in the series of the last two years. If these patients do not come under observation when the conditions are favorable, one must employ the measure giving the assurance of the greatest relief.

Spinal anesthesia with cocaine or pontocaine is preferred in these cases, for it shows the maximum degree of relaxation for extensive exploration, with the least trauma. Ether and cyclopropane are also being used. We have had no experience with the preliminary intraperitoneal vaccination as recommended by Rankin, Collier, Ransom, and others. It has been apparent that the patients who have had a preliminary permanent colostomy show a relatively higher degree of immunity for the second-stage procedures.

Blood transfusions are given, both preoperatively and later, in practically all of these cases, intravenous administration of glucose and saline solution being also used as a routine procedure following operation. Since the employment of the Wangenstein or Marriott suction we have not found it necessary to perform ileostomy.

Deep ray therapy and radium have a part in conjunction with surgery, but their use is of less benefit than in other conditions. These cases occupy a discouraging group, yet they deserve the opportunity for relief which surgery alone can supply.

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RECENT ADVANCES IN THE STUDY OF PNEUMONIA

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From the Laboratories of The Atlantic City Hospital. Read before the Section on Medicine at the 173rd Annual Meeting of The Medical Society of New Jersey, Atlantic City, June 6-8, 1939.

At the beginning of the present century pneumonia was still a disease in which prophylaxis was a dream, and treatment an uncertain quantity without specific hope or basis; for while the discovery of the pneumococcus as the etiologic agent marked an essential addition to the knowledge of this disease, in all other respects its position remained largely unchanged.

Within the last few years, however, so numerous, so important and even so startling, have been the developments in the study of pneumonia that, to some degree at least, it is hardly possible as yet to evaluate them completely and with accuracy; nor is it possible to discuss them in any detail within ordinary limits. It will be the purpose, therefore, of this discussion merely to outline certain phases of these newer developments with particular attention to their practical clinical application.

The outstanding advances in pneumonia may be regarded as:

1. The emergence of the pneumococcus as a group of serologic individualities.
2. The elaboration of specific serum therapy.
3. The development of what promises to be an effective method for the chemotherapy of this disease.

Oddly enough, the two things which have loomed so largely in the recent literature of pneumonia—the Neufeld method of pneumococcus typing, and the use of sulfanilamide and its derivatives—both mark the renaissance of neglected observations first reported over a quarter of a century ago.

It is no longer necessary to emphasize the importance of an early recognition of the type of the infecting strain in pneumococcus pneumonia, nor to elaborate upon the value of the method of pneumococcus typing first described by Neufeld in 1902¹ and again in 1931.² As everyone knows, this depends upon the marked swelling of the capsule which occurs when the pneumococcus is brought in contact with a

homologous *rabbit* antiserum. What is, perhaps, not always as clearly recognized is that there are limitations to the reliability and applicability of this very valuable procedure.

IMPORTANCE OF DETAILS IN TYPING

It is, of course, quite obvious that, in order to apply the Neufeld method of typing, one must necessarily possess some degree of familiarity with the morphology of the pneumococcus, as well as with bacteriological methods in general, for even in skilled hands the method is not infallible. As is always the case, the success or failure of laboratory procedures is in proportion to the degree with which the importance of minutia is appreciated. It is not unprofitable, therefore, to comment briefly upon some of the factors which may militate against the efficiency of the Neufeld method of pneumococcus typing.

Even when the typing serums are known to be specific and powerful, and the specimen examined to be truly sputum and not merely material from the nose and throat, various technical difficulties may result in failure to secure satisfactory and definitive results. Thus, too many organisms in the field may prevent the capsular reaction in a satisfactory degree. Likewise in a very viscid sputum, the contact of serum and pneumococcus may be so largely prevented as to prevent the occurrence of the specific capsular reaction. This difficulty may be removed either by washing the sputum with normal saline solution, the thinner washings being used for typing; or, as suggested by Rosenthal and Sternberg,³ by rendering the specimen less viscid by the addition, drop by drop, of a solution composed of fifteen grams each of borax and boracic acid in 100 c.c. of three per cent hydrogen peroxide.

It is of practical importance to appreciate that a mixture of sputum and typing serum in approximately equal volume cannot be relied upon to produce consistent results. A

proportion of 1:4 is preferred for more clear-cut results.

Where pneumococci are scanty, thus increasing the time required for the demonstration of the reaction or to assure its absence, or where the specimen contains cells and detritus in amounts sufficient to delay the reaction, various concentration methods may be utilized, such as that described by Taplin, Meneely, and Hettig.⁵

Even under the best of circumstances, satisfactory quelling reactions may not be demonstrable directly in the sputum, and may be elicited only when the organisms have been grown by culture or secured after mouse inoculation. The obvious corollary is that preservatives, particularly those which are bactericidal, should never be added to sputum specimens for typing, since culture and inoculation are thus rendered useless. However, it is of interest to note that the capsular reaction to homologous antiserum is not related to the viability of the pneumococcus for, as Harris and Varley⁶ have shown, sputum specimens preserved with one per cent formalin will still give satisfactory Neufeld reactions except in the case of the Type III pneumococcus, and such specimens may thus be preserved for demonstration and teaching purposes. Brown⁷ has also shown that the capsular reaction is not destroyed by freezing and thawing, or by desiccation; and is demonstrable after exposure to temperatures ranging from 55-75° C. for as long as one year; and that sputum smears dried on slides may be preserved indefinitely for demonstration or teaching purposes.

The inexperienced may be confused by the cross reactions which occur between types 2 and 5, 6 and 36, 3 and 8, and 15 and 30; but these may be eliminated by repeating the typing with successive serum dilutions until only one type reaction occurs.

Cumulative experience has shown that the type of the infecting pneumococcus can be demonstrated directly from the sputum in approximately 80 per cent of cases; that typing from cultures or mouse inoculation will be necessary in approximately 5-8 per cent; and

that in about 2-5 per cent of cases nontypable pneumococci may be encountered.

For reasons to be later discussed there seems to be a possibility that the administration of sulfanilamide or its derivatives prior to collection of sputum for typing may disturb or prevent the capsular reaction. For the present, at least, it seems advisable to collect sputum specimens before such therapy is instituted.

This cursory survey of sputum typing suffices to indicate that, simple as this procedure *appears* to be, its success and reliability are in no small measure dependent upon skill and familiarity with its minutia, as well as upon an appreciation of its limitations and fallacies; and here, for lack of time and space, we must leave it.

SERUM ADMINISTRATION

Specific serum therapy in pneumonia has largely emerged from the investigative and experimental stage to take a recognized place in the treatment of this disease. The results obtained by the *early* administration, in adequate dosage, of serum specific for the infecting pneumococcus strain are now so clearly evident as to require no elaboration here.

The cardinal principles essential for the successful serum therapy in pneumonia are few, and essentially simple: (1) *Early* recognition of the type of pneumococcus responsible for the pneumonia; (2) *early* and *adequate* dosage of the specific serum for the type in question, safeguarded by (3) efficient determination, and, if present, removal of hypersusceptibility to serum on the part of the patient.

These matters have been so widely and so thoroughly discussed as to require no further elaboration in this brief survey.

The disadvantages of specific serum therapy in pneumonia are, of course: (1) The lack of effective serums for all the types of pneumococci known to be involved in the production of pneumonia; (2) the difficulties attendant upon hypersusceptibility to serum, especially when intravenously administered; and (3) the time and technical dexterity incident to the safe and efficient administration of intravenous serum therapy.

CHEMOTHERAPY

For these reasons the application of chemotherapy to the treatment of pneumonia in the shape of sulfanilamide and its derivatives is attracting extraordinary attention, and is the subject of intensive investigation.

To what extent this latest advance will ultimately influence, and perhaps even dominate, the treatment of pneumonia remains to be seen; but that it will occupy a definite place in the management of this disease is certain. But before the exact status of sulfanilamide therapy can be definitely established, this drug, like many which now occupy a definite place in medicine, must pass through the inevitable cycle composed of: (1) Hyperenthusiasm, when there appears to be no limits to its value and efficiency; (2) hyperpessimism, when its dangers, complications and failures are emphasized and even over-emphasized; and, finally, (3) when time and cumulative results of continued study enable logical and unbiased evaluation, the pendulum comes to rest upon a solid basis.

We are at present, perhaps, in the first stage of this cycle. Certainly, it can hardly be denied that preliminary laboratory studies have furnished the excuse for the indiscriminate and uncritical use of sulfanilamide on an extraordinary and even unprecedented scale.

With equal certainty it can be said that there is not yet justification for the reckless and haphazard use of sulfapyridine, nor for the abandonment of serum therapy in its favor.

What is gravely needed is not statistics, but the accumulation of accurate and *critically analyzed* statistics derived from the *careful and critical analysis of carefully controlled* studies. While, on the one hand, the uncontrolled distribution of sulfapyridine for general and uncontrolled use before its potentialities are thoroughly understood may be deprecated; on the other, the untrammelled and indiscriminate use thus made inevitable may bring to light all the sooner the contraindications, the complications, and the undesirable aftermaths which may exist.

It is important to emphasize that, after all, very little is known about this drug. We do not know its index of absorption from the

gastrointestinal tract, although the great variation in the resultant concentration in the blood is already obvious, as has been shown, for example, by Marshall, Bratton, and Litchfield.⁸

We have not yet definite information as to its toxicity or undesirable after-effects, among which have been listed: cyanosis, toxic hepatitis, hematuria, anuria, drug fever, and most important of all, acute neutropenia and hemolytic anemia.

We do not know the exact manner of its action, nor the exact nature of its effect upon the pneumococcus.

In view of these and other considerations easily called to mind, we may well pause, at least momentarily, before assuming that the treatment of pneumonia may safely disregard the typing of the infecting strains, and the discarding of serum therapy in toto. These may well come, but it is well to await decisive proof of their uselessness.

Obviously, elucidation of the mode of action of sulfanilamide and its derivatives is of the greatest interest; and because the efficiency of sulfanilamide derivatives, such as sulfapyridine, seems to depend largely upon the liberation of sulfanilamide after absorption, the studies of one are applicable to the effects of the other.

Indeed, the pneumococcus itself has always been somewhat of a bacteriologic mystery; for despite the profound reactions consequent upon its invasion of the tissues, but little has been found in the study of cultures to account for their occurrence.

Although the pneumococcus was first adequately described in 1886, it was not until 1923 that attention was first focussed upon its capsule as the source of a specific polysaccharide capable of inducing a definite tissue reaction and also antigenic response. Subsequent investigations have shown the diffusibility of this soluble specific substance, and demonstrated the importance of the capsule as a protection against phagocytosis and, perhaps, an inhibitor of antibodies.

It is known that the specific effect of anti-pneumococcus serum depends upon its ability to neutralize the diffusible soluble capsular substance; and while there is a great deal

final information as to the *modus operandi* of sulfanilamide, it is possible that its effects, in part at least, may also be related to some action on the capsular substance.

Sulfanilamide is neither essentially nor definitely bactericidal, but has been shown to be definitely bacteriostatic. This has been quite clearly demonstrated by many workers and particularly by Osgood⁹ in his studies of human marrow cultures.

Lockwood, Coburn, and Stockinger¹⁰ report that from their studies the most striking effect of sulfanilamide was a depression of the invasive properties of the organism; and they add the further and important observation that the efficiency of sulfanilamide therapy seems to be in relation to the type of lesions, being influenced by the amount of tissue debris. Whether this was the result of a protective action exerted by the debris *per se*, or because it served to limit the degree of contact of the drug with the organisms, is not yet clear.

Various studies have failed to demonstrate any antitoxic action, any specific inhibition of specific hemolysins, or any bactericidal powers for this drug.

All that is so far known is that it is bacteriostatic; and that, by analogy, it may exert some action upon the capsular substance and produce some structural change in the pneumococcus as a whole, thus rendering it more vulnerable to the action of the immune mechanisms mobilized to combat the disease, including, particularly, phagocytosis.

In this connection, as there is some possibility—though this has not yet been clearly demonstrated—that sulfanilamide may interfere with the action of pneumococcus typing serum, it is advisable that typing be done before the drug is administered.

In the last analysis, recovery from pneumonia is in direct proportion to the ability of the patient to develop specific antibodies in sufficient quantity to neutralize the diffusible specific soluble substance elaborated by the pneumococcus, and sufficient bacteriolysins, opsonins, and so on, of sufficient potency to attack the pneumococcus and, together with phagocytosis, to destroy it.

All of these are essential. Neither one nor the other suffice alone.

It is apparent that, by its bacteriostatic action, its ability to inhibit aggressions, and by its possible effect on the pneumococcus structure, as well as its possible effect upon the production of toxins, sulfanilamide is certainly a valuable adjunct in the treatment of this disease.

Contrary to logical expectations, there appears to be no clear nor constant relation between the effects of sulfanilamide and its concentration in the blood. In fact, because of the variability in its absorption index, the blood concentration ranges from 2-6 mgms. per 100 c.c. regardless of dosage which is, therefore, somewhat empirical.

In a recent and carefully controlled series of fifty cases treated with sulfapyridine with four deaths, or a mortality of eight per cent, St. George, Kraetzer, and Magee,¹¹ report that though the dosage was relatively constant, the average concentration in the blood never exceeded 6.5 mgms. per 100 c.c. These authors regard 10 mgms. per 100 c.c. as the upper limit of safety.

In the last analysis, though there is good reason to believe that means for the long-sought-for chemotherapeutic attack may be at hand, there is as yet no clinical justification for the discarding of specific serum therapy in favor of sulfanilamide therapy alone. It may well be that experience and the test of time and trial will demonstrate that the ultimate conquest of pneumonia may come through a combination of serum therapy and chemotherapy. Certainly, the therapeutic outlook in pneumonia is better now than ever before.

This does not mean that pneumonia as a disease requires no further study. On the contrary, not only does it still present problems for solution in relation to its bacteriology and its pathology, but recent reports suggest that its etiology also has still, perhaps, not been solved in its entirety. Reimann,¹² for example, has recently reported eight cases of an atypical pneumonia in which a filtrable infectious agent was recovered from the nasopharynx of one patient and from the blood of another.

So it may be that, just as the way to victory

appears to open in the case of pneumonia as we have hitherto known it, a new species of the disease appears to challenge the skill and the patient perseverance of investigator and clini-

cian alike. Even if this be so, we can remember that the attack of medicine upon the problems of disease, if slow, is also relentless and unending.

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Atlantic City Hospital

IS RESPIRATORY INFECTION AN ETIOLOGIC FACTOR IN BRONCHIAL ASTHMA?

By HARRY L. ROGERS, M.D., Riverton, N. J.

Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey, June 7, 1939.

From all clinical allergists, the answer would be "yes". However important infection appears in the eyes of all, there would be a vast difference of opinion in the mode of operation (mechanism) and in the treatment advised.

Allergic respiratory disease is insidious, and the true onset, characterized by intermittent, and later chronic, edema of the mucous membranes, may be present for years without causing clinical symptoms. However, the person is very likely to date the onset to some dramatic episode which brings the process to their attention (pneumonia, a tonsillectomy, or one of the exanthemata).

Two possibilities may exist in frankly infected persons: 1, The infection was primary and is the cause of the asthma; or 2, a low-grade, almost symptomless allergy existed in the mucous membranes, particularly of the nose, for many years before this diseased membrane becomes infected.

Unfortunately, in the reported series of "infectious asthmas", careful clinical observation

in the years preceding the onset of asthma is not available, so that, from the literature, either possibility can be supported. Our impression is that allergy is the primary condition.

Cooke and Grove¹ believe that in the hyperplastic cases the infection is primary and the asthma a result of sensitization to the infection. On the other hand, Kern and Schenck² believe that sinus disease is as prevalent in non-asthmatics as in asthmatics; and Bullen³ could find only twelve and a half per cent of a group of 400 infected sinuses in whom the patients also had asthma. Other observers have placed the incidence of sinus disease from 27 to 75 per cent.⁴

Great confusion exists among allergists both as to the incidence and the etiologic importance of infection; but almost all allergists have witnessed a parallelism between the degree of infection and the severity of asthma, and yet few have hazarded a guess as to the mechanism involved. Occasionally, vaccine injections will be followed by an attack of asthma or an

aggravation of the already existing asthma. This is not a constant finding, but has been observed often enough to rule out coincidence. On the other hand, most observers agree that a reliable urticarial, or even inflammatory skin, reaction to killed bacteria does not exist. Certainly the infective mechanism differs radically from that due to common allergens, such as pollens and animal dander.

To sum up our present knowledge of infection in asthma:

1. Actual infection exists in a fairly large percentage of persons suffering with asthma.
2. The severity of the asthma varies directly with the severity of the infection.
3. Improvement in the asthma follows the eradication or improvement of the infection.

In our experience, an acute rhinitis or bronchitis, or one of the milder respiratory infections which sweep through a household, office, or school room, are repeatedly the spark which sets off the powder. Individuals whose asthma has been under control for a considerable period of time will again and again have asthmatic attacks as a result of these intercurrent infections, this despite the fact they have been treated over a long period with stock catarrhal vaccines. When these individuals can pass through these infections without developing asthma, we feel that we have their asthma well in hand.

Infections in parts of the body other than the respiratory tract have little if any influence on asthma. The infection which interests the allergists occurs in the nasal sinuses, teeth, tonsils, and bronchi. These are now discussed in some detail, giving methods of diagnosis, and the principles of treatment now in practice at the Jefferson Clinic. We are not at all convinced that these are ideal, nor are we satisfied with the results. We earnestly hope that we will be able to improve upon them from time to time.

TONSILS

If tonsillectomy cured asthma, there would be little excuse for the existence of an allergist. Fully 50 per cent of all persons consulting us these days have had their tonsils removed.

It is quite true that an acute tonsillitis can

aggravate an already existing asthmatic attack. However, in these instances there is usually an accompanying infection in the nose and bronchi. Certainly, any tonsil that is subject to repeated attacks of acute inflammation should be removed. On the other hand, we are occasionally confronted with the problem of the chronically infected tonsil, without any acute episodes, but with continuing asthma. Under such circumstances, tonsillectomy will too often prove to be a disappointment.

Our general rule in clinical practice has been to decide the question of tonsillectomy on the same criteria that we would use if the person did not have asthma.

TEETH

While the teeth are not a part of the respiratory system, their proximity, blood supply, and lymphatic drainage make them a very definite factor. We have seen on occasion, unfortunately only too rarely, a dramatic cessation of asthma following the removal of a frankly abscessed tooth.

INFECTED SINUSES

It is our impression that infection, characterized by actual pus formation in the sinuses, occurs in only about 10 per cent of our asthmatic patients, in spite of the fact that some clouding of the sinus, as shown in the x-ray films or on transillumination, occurs in 75 per cent.

These frank infections in the sinuses, which are characterized by pus and the presence of pathologic bacteria, have a most deleterious effect upon asthma. Frequently, the severity of the asthma varies directly with the severity of the infection. Once we have the co-existence of asthma and purulent sinusitis, any discussion as to which is cause and which effect, becomes purely academic. The therapeutic indications are obvious—eliminate the infection.

To do this, first, it is necessary to establish drainage. This can be accomplished by two methods: 1, allergic; and 2, surgical. The mucous membrane, intensely congested as a result of contact with the specifically reacting allergens, will prevent drainage, just as effectively as the most crooked septum, or the

largest polyp. Abnormalities of the septum, such as spurs and deviations, if sufficient to cause obstruction, must be considered as predisposing to infection. However, we prefer to give these individuals the benefit of two or three months of allergic management before operation.

Clinical judgment, after adequate study and consultation between the allergist and the surgeon in the individual case, must be observed. Generalization is impossible.

Great care must be taken to recognize the benign swellings without real infection, seen so frequently in the nasal mucous membrane. Such a membrane will cast a decided shadow on the x-ray film; and if this membrane is subjected to radical surgical procedure, severe and intractable infection, even to the point of the development of osteomyelitis, may result. This type constitutes the biggest problem in clinical allergy, and it is in this group that the most serious mistakes occur.

INFECTION IN THE BRONCHI

Probably of as great or even greater importance than infection in the upper respiratory tract is infection in the trachea and bronchi. This is most difficult to diagnose, and is probably always secondary to the allergy. The chief diagnostic points are:

1. The history of acute exacerbations of cough and fever, with purulent expectoration.

2. The finding of moist râles intermittently or constantly, particularly over localized areas of the lower lobes (a favorite location for these râles is in the axilla).

3. Characteristic findings in the x-ray (easily confused with bronchiectasis).

4. The direct findings in the trachea and bronchi as seen through the bronchoscope.

Chronic bronchitis must always be considered before any radical surgical work is advised in the nose.

While infection in the upper respiratory tract is a decided factor in infection in the lower tract, radical sinus operation alone will not produce a cure. Certainly an attempt should be made to clear up any co-existing bronchial infection before resorting to radical nasal surgery. On the other hand, our attempts to clear up bronchitis frequently meet with failure until proper attention has been paid to the sinuses; but here again, a most difficult problem can only be met by proper clinical judgment in the individual sufferer.

CONCLUSION

1. Infection in the respiratory tract is very difficult to diagnose in the presence of allergy.

2. When infection does occur, the deleterious effect is very great.

3. Treatment is tedious and difficult, and can only be decided upon after careful clinical study.

4. From the foregoing observations of our own and the work of others, the question as to whether infection is a primary factor in the etiology of bronchial asthma cannot be answered—it is, however, a very definite, complicating factor.

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ACUTE SUPPURATIVE MEDIASTINITIS REPORT OF A CASE

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From Surgical Service, Newark Beth Israel Hospital

In the past two years, there have come under our observation six cases of acute suppurative mediastinitis. These cases, because of their dramatic onset, singular pathology, deceptive clinical manifestations, and high mortality, have aroused our interest in this condition. The suggestion of a surgical approach to this condition has heretofore been greeted with an attitude based upon the opinion that the operations was extremely difficult and dangerous, resulting in hesitancy fed by a futile hope of a spontaneous recovery. In two cases the condition was diagnosed and the patients were observed conservatively until exitus; in two cases the condition was undiagnosed during life; in another, surgery was resorted to only when the patient was almost beyond hope; and in the final case, the diagnosis was made and surgery proved a life-saving measure.

TYPES

The three most common types of acute infections of the mediastinum are:

1. Acute suppurative mediastinitis (localized abscess).
2. Acute phlegmonous mediastinitis (generalized).
3. Acute mediastinal lymphadenitis.

The vast majority of these cases result from two sources: First, contiguous spread from infections of the neck such as retropharyngeal abscess and suppurative cervical adenitis; and second, traumatic injuries of the esophagus.

In the first group, namely, suppurative lesions of the neck, the pus descends along the fascial planes into the mediastinum and, according to Neuhoff, set up a localized abscess in the superior mediastinum. The non-suppurating infections of the neck, such as acute pharyngitis, produce either a phlegmonous mediastinitis or a non-suppurative mediastinal lymphadenitis.

The second group, namely, the traumatic lesions of the esophagus, result in an acute suppurative mediastinitis with abscess, or acute

phlegmonous mediastinitis. When confronted by a suppurative lesion of the neck or a traumatic lesion of the esophagus, one should be mindful of the receptive mediastinum which is in constant motion exerting its negative pressure on the lesion above, due to the act of respiration. The mediastinum is a potential space which contains, besides loose areolar tissue and lymphatics, some of the most important structures of the body such as the heart, esophagus, trachea, etc. As a result, it is not very resistant to infection; and once the infection has spread to this locality, the absorption of toxins produce a severe and rapid toxemia.

MANIFESTATIONS

Manifestations are so variable as to preclude any typical description of acute mediastinitis. The phlegmonous type most often produces severe toxic symptoms, while the localized form may produce comparatively mild symptoms. With a persistent cervical infection that fails to respond to treatment within the usual period, and evidence of severe toxemia and prostration is present, mediastinitis should be thought of, and a complete x-ray study including a lateral view of the superior mediastinum should be made. Every case of retropharyngeal abscess or suppurative cervical adenitis that has been incised and drained, and continues with symptoms of suppuration, should have a routine x-ray study of the superior mediastinum. Every case of trauma to the esophagus should be routinely x-rayed; and if evidence of perforation is present, operative treatments should be considered. The history very often is the most important factor in arriving at the diagnosis.

PHYSICAL SIGNS

Physical signs of acute mediastinitis are never constant, and are usually negative. Percussion tenderness over the spine may be elicited in posterior mediastinitis. However, in extension of cervical suppuration into the

mediastinum the position of the trachea is affected. It is always displaced forward and it may be displaced to right or left. In attempting to place a finger in the suprasternal notch, pain will be elicited. Bi-lateral pleural involvement is not an uncommon finding in this condition.

Roentgenological signs are often diagnostic in lesions of the superior mediastinum, especially when a fluid level is visible. In other regions of mediastinum x-ray findings are often negative due to the super-imposed heart shadow.

CASE REPORT

F. K., white male, twenty-one years of age, admitted June 24, 1938; chief complaint, pain and difficulty in swallowing. About three weeks previously patient accidentally swallowed some lye. He was removed to a private hospital where he was treated for twelve days. On June 21, 1938, a bougie was passed to dilate the esophagus because of persistent pain referred to the precordium and difficulty in swallowing. X-ray with barium revealed a constriction at the lower end of the esophagus. Following this procedure the patient developed severe pain, vomiting, and fever, ranging between 103 and 104 degrees. Three days later he was admitted to the Newark Beth Israel Hospital.

The physical examination on admission disclosed no physical signs except those accompanying any moderately severe infection. Temperature on admission was 101 degrees, blood count was 7800 with 63 per cent polymorphonuclear leukocytes and nine immature white cells. Temperature continued to be elevated between 101 and 103 degrees. On June 27th, three days later, an x-ray report of the chest disclosed a left pleural effusion with probable exudative infiltration of the underlying lung. On June 29th, two days later, physical examination by medical service revealed evidence of consolidation or atelectasis of left lower lobe with pleural effusion. Further observation and x-ray study was advised.

On July 2nd, aspiration of the left chest and replacement with air to help visualize the mediastinum was done. At that time, the possibility of a periesophageal infection following the instrumentation of June 21, 1938, was thought of. Perforation of the esophagus was not considered because of the absence of mediastinal emphysema. After 120 c.c. of clear amber fluid was removed, which on culture revealed streptococci, the pleural involvement was considered to be secondary to a mediastinitis. The x-ray film at this time reported involvement of the left lung with displacement of the heart to the right and no mediastinal infection. On July 9th a definite pleural friction rub was heard over the right base. The bilateral pleural involvement pointed more strongly to a mediastinal infection although the x-ray reported no pathology on the right side.

At this time there was a general remission in symptoms and temperature, and the patient reported less difficulty in swallowing semi-solid food. Sulphanilamide treatment was started at this time. Symptoms and temperature increased, and on July 14th, another chest tap revealed similar clear amber fluid which was sterile on culture. On July 20th, aspiration of the chest close to the mediastinum in the ninth interspace yielded bloody, thick, foul pus. Direct smear of this pus showed Gram positive bacilli and chains of cocci. Culture showed streptococci viridans, bacillus pyocyaneus, and anaerobic Gram positive bacilli. At a consultation it was decided that the patient had an abscess of the mediastinum and the only treatment was operative. X-ray at this time did not localize the infection.

The following day, July 21st, posterior mediastinotomy was performed under paravertebral and local anesthesia. On entering the mediastinum after reflecting the thickened inflamed and adherent left pleura away from the spinal column, a large periesophageal abscess containing thick foul pus was evacuated by suction. Culture of this pus disclosed the same bacteriology as the last aspiration. No perforation of the esophagus could be demonstrated. The cavity was packed with iodoform gauze, one piece of rubber tube and one corrugated rubber drain.

The patient made an uneventful recovery and, in about one week, the temperature became normal. On August 6th, two weeks after operation, the patient was allowed out of bed. One week later patient began to have difficulty in swallowing. This progressed until he could not swallow liquids due to the progressive stenosis of the esophagus. It was decided to start dilating the stricture. A string was swallowed by the patient and the next day an esophageal bougie No. 23 was passed along the string. Methylene blue was swallowed on two occasions to see if an esophageal fistula was present; this was negative. On August 24th, 1938, the patient was discharged after a number 31 bougie was passed.

His condition remained excellent and he was swallowing food with ease until September 28th, 1938, during which time he received bi-weekly dilations. On that date he suddenly had a severe hemorrhage and was readmitted to the hospital on October 2nd, 1938. He continued to bleed by mouth varying amounts in spite of medical treatment and discontinuance of all feeding. On October 13th, 1938, an esophagoscopy was performed which revealed a large amount of granulation tissue, the source of the hemorrhage. A string was passed down into the stomach. A gastrostomy was performed and the end of the string was brought through the gastrostomy tube. This was followed by a blood transfusion. After another blood transfusion on October 16th, he began to recover rapidly and was discharged from the hospital November 14th, 1938.

At the present time the patient's condition is excellent, and he is still receiving weekly dilations and swallows food without difficulty.

TIBIAL BONE GRAFT FOR CLAVICULAR DEFECT REPORT OF A CASE

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This paper presents a successful result of a tibial bone graft for a repair of the loss of the medial one-half of a clavicle.

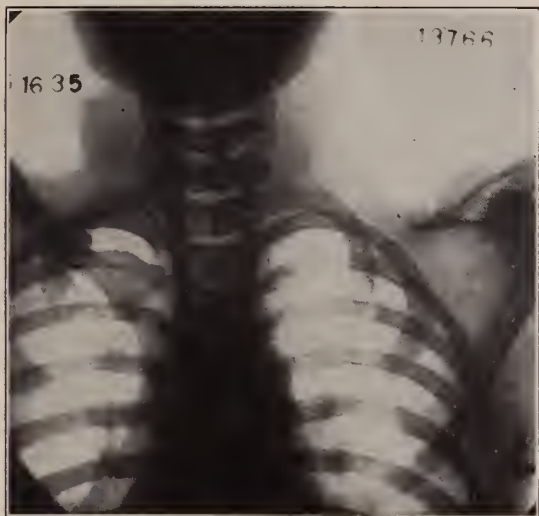
The literature on clavicular operations is scanty. That good function sometimes follows total excision of the clavicle has been shown by Coley. Soutter in 1924 described a useful incision for exposing the clavicle without leaving an unsightly scar. There are a few articles describing operations for fresh and ununited fractures of the clavicle, and numerous writings on reduction of acromioclavicular dislocations; but no report can be found on the repair of a large clavicular defect as is here described.

Roentgenogram showed a sequestration of the middle third of the left clavicle, and a multiple abscess cavity in the greater trochanter. A diagnosis of osteomyelitis was made, and the child was prepared for operation.

On January 15, 1935, a sequestrum about three inches long was removed en masse from the clavicle, and an abscess cavity in the greater trochanter was saucerized, both areas being packed with vaseline gauze.

The boy made an uneventful post-operative recovery and was discharged to the Country Home on February 25, 1935.

The clavicular area healed rapidly but by May it was learned that there had been no regeneration of bone. An x-ray at this time showed that the proximal portion of the left clavicle could not be visualized except for a small piece adjacent to the sternum.



X-ray of R. E. before operation



X-ray of R. E. after operation.

CASE REPORT

R. E., aged ten years, was referred to the hospital on January 10, 1935, because of a discharge of pus from about the left collar bone, and because of a painful right hip. The history was that of having had an abscess over the left collar bone incised and drained following a painful swelling that had developed after a minor injury to the shoulder fifteen months previously. Not long after the clavicular trouble started the region of the right hip had become painful and swollen and remained so to the date of admission.

Examination showed multiple draining sinuses about the left clavicle which was exposed in the region of the middle third. There was a swollen and tender area over the greater trochanter, but passive hip motion was relatively free and painless.

The trochanteric wound healed more slowly, and in September an abscess cavity was evacuated. After this the area rapidly filled in, allowing the boy to be returned to the hospital for operation on the clavicle.

On November 28, 1935, on return to the hospital, examination of the shoulder showed scarring over the left middle third of the clavicular area, with the medial one-half of the clavicle missing. There was a scar over the right hip with no limitation of motion of the hip joint.

The left clavicular area was prepared for operation, and a tibial bone graft operation was performed on November 29, 1935.

Operation.—An incision was made over the medial one-half of the left clavicle. The sternal portion of the clavicle was found to be a spicule of bone one-

half inch long; the sternoclavicular joint was not exposed. The end of the distal fragment of the clavicle was a poor substance, soft and friable. Between these two points the muscular tissue was separated, revealing between the bone ends nothing but a fibrous band. No periosteal tissue could be identified.



Voluntary elevation of the arm after operation

A heavy piece of tibia four inches long was removed, with the periosteum attached. A hole was drilled in one end of this graft and fitted over the short spicule of bone that remained at the sternal end of the clavicle. The other end of the graft was fitted to the outer fragment of the clavicle by dovetailing.

Two osteoperiosteal grafts were removed from above and below the site from which the bone graft had been removed and were wrapped around the ends of the bone graft and sutured in place. The musculo-aponeurotic layers were closed over the bony bridge under some tension, and the superficial tissue and skin were closed in layers. A shoulder arm spica was applied, holding the arm in a neutral position.

The patient made an uneventful post-operative recovery. On December 24th, about a month later, an odor was noticed from the cast, and on examination of the wound, it was found that the suture line had separated, but the graft was covered except for a small area by healthy granulation tissue. The boy was kept in the hospital until March 23rd when he was discharged to the country home.

During the period of convalescence the wound was infrequently dressed with occasional trimming of granulation tissue. By April 15th the wound was completely healed. The plaster was removed on May 14th, about six months after the operation.

During this period the sinus from the trochanteric area had remained open. This finally closed and the boy was discharged home on August 3, 1936.

He was seen in the Out-Patient Department regularly for a period during which time a final abscess of the hip was incised. On August 24th this had completely healed.

A follow-up on December 29, 1937, revealed that the boy had full function of the arm, and had for many months been engaged in all school-boy athletics, even to pitching baseball with the operated extremity. At this time it was noted that he was left-handed and was using this left operated extremity to the full degree.

Examination showed considerable scarring over the clavicle, and a bony prominence at the sternal clavicular end of the graft. The bone graft had assumed the normal contour of a clavicle. Careful measurement showed a shortening of the left clavicle of about one-half inch as compared to the opposite side. There was, however, no obvious deformity of the shoulder girdle as seen from the front or from the rear. There was full motion of the shoulder girdle and arm in all directions.

COMMENT

In considering this case it will be recalled that the soft tissues were sutured over the bone graft under some tension. The tension was too great and the tissues separated. This might have been avoided possibly if the incision as described by Soutter had been used. Separation of the skin and superficial tissues might have been avoided if a counter incision had been made and the skin and soft tissues moved upwards to avoid tension over the graft. It is also interesting to note the manner in which the graft in the course of time assumed the contour of a normal clavicle.

CONCLUSION

1. Because of the paucity of literature on the repair of clavicular defects, an example of a tibial bone graft for the repair of the loss of the medial one-half of a clavicle has been presented.

2. It is believed that the difficulties met in this case may be of use to other surgeons.

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THE NEW JERSEY ADOPTION LAW AND ITS RELATION TO THE PHYSICIAN

ADOPTION OF CHILDREN—ARTICLE NUMBER ONE

By ELLEN C. POTTER, M.D., Director of Medicine, New Jersey State Department
of Institutions and Agencies, Trenton, N. J.

Under the old law anyone could place a child for adoption, and no questions were asked. There were no required safeguards placed about the child, the unmarried mother, or the adopting parents; there was no central place of record of adoptions; and the confidential nature of the records was not assured.

The American Legion Child Welfare Committee, and the New Jersey Welfare Council, sponsored the amendments to the law which became effective January 1, 1939, and were designed to improved adoption practices in this State.

How does the new law affect the physician?

Neither the physician, nor any other individual may place a child for adoption without having the merits of the case investigated by order of the Court before the petition is heard.

The Court is required to order such an investigation; and may utilize the Department of Institutions and Agencies or an incorporated child-caring agency for this purpose. The Department may be appointed as "next friend" to give consent to the adoption when this has not been secured from the parent.

Good adoption practice requires that a child shall be at least six months old before being placed for adoption, and that the child should live in the new home at least twelve months as a test of adjustment before the adoption decree is granted.

Every precaution must be taken to assure that the child is sound in mind and body. The placement should be made, if possible, in a home of the same religious belief as that of his natural parents; and it should be a home in which there is good health, harmony, and sufficient means to provide for his welfare. The racial heritage of the child and the adopting parents should be given consideration in making placement.

Never should pressure be exerted on the unmarried mother to give up her child. If it is her ultimate decision to give up the child,

then the legal consent must be executed in order that all parties to a subsequent adoption may be protected.

How can the social agency serve the physician in these problems?

Since informal, immediate placement of children for adoption is now by law subject to review, and is hedged about with legal safeguards, the incorporated child-caring agency can do much to serve the physician in some of his problem cases.

It can relieve him of the technical detail involved in the procedure of adoption.

It can assist in the evaluation of the child, and the adoptive home.

It can help the unmarried mother in the solution of her problems, and can provide temporary care for her and for her child when needed.

The Department of Institutions and Agencies can provide information as to qualified agencies.

The physician can help the social agency and those who see children for adoption by:

Informing prospective mothers of the services of qualified children's agencies.

Directing persons wishing to adopt to such agencies.

Interpreting the importance of a medical examination for the child and the parents.

Giving needed information to the agency for the case record of the child.

Not all adoptions are of illegitimate children; they constitute only about 50 per cent of all adoptions in New Jersey. The law on adoptions applies to all children, in all family relationships.

In all these cases there is need for medical service and advice. The physician and the social agency, each in its field of competence, has much to contribute in this field of child welfare.

A series of sketches of the problems of adoption will follow in future articles.

CONSTITUTIONAL INADEQUACY

By WALTER C. ALVAREZ, M.D., Mayo Clinic, Rochester, Minn.

Read before the Section on Gastro-Enterology of the Annual Meeting of The Medical Society of New Jersey,
June 8, 1939.

Much of the disease and disability which the internist sees each day is due to a constitutional frailness, or biologic inferiority of the patient's body. The "contractor seems to have put in such poor materials" that throughout life one organ after another keeps breaking down. The oculist may do his best for the patient's weak eyes, the orthopedist may fit a brace to the weak back, the gynecologist may inject ovarian extracts, the cardiologist may treat the palpitations, and the gastro-enterologist may give diets and belladonna, and all that results is that the patient goes next to the urologist with an irritable bladder or to the allergist for a stuffy nose.

Often there is poor resistance to infection, and great difficulty in getting over colds, or accidents, or operations. Usually there is much hypochondriasis and fear of disease, or much hypersensitiveness which causes little discomforts to feel like unbearable pains. As a result the patient spends most of his or her substance on medicine and operations and examinations. Almost always there is bitter complaint of sensations of exhaustion, and not infrequently the patient is so psychopathic that all the problems of living and adjusting are made difficult; the brain is in such constant turmoil that rest and relaxation and proper sleep cannot be attained, and little energy is left for happy and productive work.

Unfortunately this common disease is not sufficiently well known; it is not described in textbooks; the victims are not shown to medical students; and the problem is rarely discussed at medical meetings. As a result, these patients are usually badly treated. They are put through one lengthy and expensive examination after another, and often they are subjected to what prove to be fruitless operations.

The patient insists that some day the cause of the trouble must be found in thorax, or

abdomen, or teeth, or tonsils, or glands of internal secretion; and unfortunately his physicians commonly agree with him and keep on searching. They say "Ha, we've found it" every time they find a little ptosis, or some spasticity of the colon, or a slightly low basal metabolic rate, or low blood pressure, or low blood sugar.

Physicians commonly realize that the patient's brain is at fault; and that the troubles are largely due to a poor nervous heredity, and to much strain through overwork, unhappiness, or worry and fussing, but not often enough as yet do physicians insist that this diagnosis of constitutional inadequacy is sufficient to explain all the pains and feelings of fatigue, and that it will be only a waste of time and money to look further.

It takes much clinical wisdom and courage and finesse to do this, because such a diagnosis is commonly abhorrent to the patient, and he or she commonly becomes angry and refuses to accept this dictum. Most persons would rather keep on looking for some short-cut to perfect health, and most would probably rather keep on paying out hundreds of dollars for useless treatments than to face the unpleasant fact that they cannot expect to be perfectly comfortable, but that they must learn self-control. They must stop worrying and fretting and hoping for a big cure, and must settle down to learn to live with a frail body and poor nerves.

In most cases the cause of the trouble appears to be the inheritance of an unstable nervous system. Often insistent and tactful questioning will bring out the fact that there is insanity, or some equivalent of insanity, in one or more members of the immediate family. The patient's extreme fatigue is sometimes only his share of the family curse that sent his mother into an asylum after her menopause, and caused his cousin to be a useless ne'er-do-well.

CARE DURING THE SECOND STAGE OF LABOR

MATERNAL WELFARE ARTICLE NUMBER FORTY-TWO

By WALTER B. MOUNT, A.B., M.D., F.A.C.S., Montclair, N. J.

Attending Obstetrician, Mountainside and Montclair Community Hospitals

Read before the Section on Obstetrics and Gynecology of the Academy of Medicine of Northern New Jersey, March 2, 1939, and before the Physicians' Clinical Society of Union County, N. J., March 27, 1939.

Exhaustive remarks on all aspects of this subject will not be attempted here, as they can be found in text-books. We merely wish to mention certain important points.

Care during the second stage of labor of course is predicated on the care in the first stage. With the onset of the bearing-down contractions we know so well, the question arises,—should we always make a vaginal or a rectal examination to determine the condition of the cervix and the level and position of the head? Not if we feel that labor is progressing satisfactorily; otherwise a complete check-up is in order, preferably with the patient draped on the delivery table, and under an anesthetic. The patient should be transferred from her room or the ward to a labor room if this has not been done already. She should be put on the table and scrubbed up early enough to avoid confusion, and hurry, and incomplete preparation.

The physician in charge should be in the hospital and usually in the region of the delivery suite during all of the second stage. During this time he should be quickly available, in a white suit, and should not plan to do other work.

ANESTHETICS

The administration of inhalation anesthesia, intermittently with the pains, is usually considered routine throughout the second stage. Nitrous oxide gas and oxygen seems the best. Ethylene is highly recommended by De Lee. Ether is less pleasant, and a bit less satisfactory. Chloroform is still used in some of our Southern States and in England, but might well be discarded because of its proven bad effect on the liver. If, as the result of analgesic drugs given in the first stage, the patient is especially drowsy, she may not give warning of the onset of contractions and the anesthetist himself will have to watch the abdomen;

and she may not cooperate in holding her breath and bearing down. This use of the voluntary forces should be stressed, but of course only in the second stage. Spinal anesthesia as given by experts has proved satisfactory. It increases the incidence of low forceps deliveries, but it allows the perineum to relax nicely. Local anesthesia might be given a trial but we have never seen it used; the same holds true of sacral anesthesia. De Lee urges their use.

We feel very strongly that a real anesthetist should administer the anesthetic for the same reasons that the surgeons insist on properly trained anesthetists in their work,—because the patient's best interests are served. For ward patients internes may be used after they have had instruction in the anesthesia department. In one hospital a recent ruling requires one of the anesthetists to be on call for all ward deliveries. Trained nurse anesthetists are satisfactory; but their routine employment opens up serious questions which will not be discussed here. After delivery a capable anesthetist may be of inestimable help in reviving an asphyxiated baby.

If the anesthesia must be deepened and made continuous, as for a vaginal examination, rotation of the head, version, the use of forceps, etc., skillful administration is essential. For continued anesthesia cyclopropane may be the best anesthetic; the high percentage of oxygen used with it makes it very safe, especially for the fetus, and muscular relaxation is excellent. It does not lend itself particularly well to intermittent administration. Nitrous oxide given continuously for more than a few minutes should be mixed with at least 15 per cent of oxygen to prevent the danger of asphyxiation of the fetus.

Sedative drugs by mouth or by injection or by rectum are useless and therefore contraindicated in the second stage. A retention

enema is just not retained. The anesthetist may at times order certain drugs of which he appreciates the necessity.

RUPTURING THE MEMBRANES

If the membranes have not ruptured near the beginning of the second stage, it is wise to rupture them artificially; failure to do this may delay progress, and not infrequently their rupture is followed by more rapid advance.

FACE MASKS

Face masks should be worn by all who come in contact with the patient. The mask should cover the nose as well as the mouth. The gauze mask, even one of several layers, is at best a filter and becomes less efficient as time passes. It may be used for a few minutes at a time. For any prolonged use, as by the nurse watching the patient, or for the actual delivery, an impermeable mask is much safer for the patient, and it is more comfortable for the wearer because it has more breathing space. We prefer the Harley gauze cellophane mask. The Waters mask (1936) of plastocene is more durable and hence less expensive. When using these masks one must prevent the dropping of perspiration by placing a piece of cotton at the bottom when necessary, as in hot weather, because the masks have no absorptive properties.

VISITORS

The family or visitors should be excluded from contact with the patient during all of this time and should be kept out of the delivery suite. In certain instances one must remember to keep the family informed in some way about the patient's progress. While the physician should be nearby, he need not be with the patient all of the time if an anesthetist is present. A nurse watches the patient. We deprecate the frequent practice by nurses of separating the labia during contractions in order to obtain a better idea of the descent of the head; it increases possibilities of infection.

FETAL HEART SOUNDS

The fetal heart was first heard for a certainty in 1818 by Mayor, of Geneva, two years

after the discovery of the stethoscope. Several straight stethoscopes can still be obtained and some of these are still being used. The ordinary stethoscope is improved by having a soft rubber tip (a cut nursing nipple) on the end, and by the use of two rubber bands to hold it steady against the patient's body and prevent friction sounds. Watching the fetal heart is especially important in the second stage of labor; at this time it is advised that one should listen every five minutes, or after every contraction. Many like the Leff stethoscope or Leffscope (1930), or one of the head stethoscopes, of which several have been devised. The Wechsler stethoscope (1932) has one great advantage over the others; the tip is boiled with the instruments, screwed on with sterile gloves and hence can be applied directly to the sterile sheet over the abdomen without disarranging it. Nurses are easily trained to watch and record their findings, and to report abnormalities in quality, in regularity, or in rate (below 100 or over 160). They enjoy the responsibility.

When the physician is scrubbed for delivery and the patient scrubbed and draped, the Leff stethoscope can be slipped easily under the sterile sheet by a non-sterile attendant. Or, by the use of a head stethoscope, the obstetrician can obtain direct information about the fetus instead of having it relayed to him. The Falls instrument (1925) carries a watch which is reflected in a magnifying mirror, but it cannot be used with bifocal lenses. The sort of clock used for many years by De Lee (1927) rings a bell every fifteen seconds to aid one in counting the fetal heart; however, it is expensive, and it has been observed to be out of order in several hospitals where it was installed. Our own electric timer serves the same purpose and has been in use now for four years. In 1926 von Wachenfeldt of Sweden devised a timer made from an alarm clock. Other electrical devices for amplifying and recording the fetal heart, including the electrocardiogram, are expensive or not practical, but may promise much. Four we investigated recently were not in use.

When the fetal heart remains slow or irregular or weak, we interpret it to indicate fetal

distress. How then shall we help? If dilatation of the cervix is complete and other conditions good, prompt delivery, often by the help of forceps or episiotomy, has saved babies where the trouble was a short cord, a cord about the neck, a knot in the cord, or premature separation of the placenta. In other cases, with a long labor, hard contractions, and some unfavorable presentation or position, we may aid by deepening the anesthesia in order to relieve pressure of the uterus on the fetal circulation, or we may better the position of the head, or break up an impacted frank breech, as Goethals states should usually be done. It may be necessary to push up the baby temporarily. Manual completion of dilatation of the cervix, or incision of the cervix, has helped and occasionally should be done.

Brief reports of illustrative cases may impress these points.

A gravida two had four fingers' dilatation, and was getting gas-oxygen intermittently. The membranes were ruptured artificially, and a brow presentation was diagnosed. Just then the fetal heart could not be heard. Anesthesia was made continuous and ether added, while the head was pushed back and converted into a face with the chin anterior. Within nine minutes the fetal heart was heard again. Spontaneous delivery occurred half an hour later.

In another patient application of mid forceps to an occiput posterior position slowed the heart much. Another make of forceps was applied and locked with no such result. The cord was about the neck loosely and dropped alongside the face at delivery, probably was caught in the grasp of the first forceps used.

Fetal heart abnormality quite late in the second stage may indicate a short or shortened cord, or premature separation of the placenta.

The local preparation, and the draping of the patient on the delivery table we will not describe in detail.

PREPARATION OF THE PATIENT

Soap is probably very important. Doctors and nurses should scrub adequately. We prefer to use vaginal instillations of some antiseptic solution before a vaginal or a rectal examination, and again when the patient is prepared on

the table. Catheterization is done for distended bladder, and routinely on the table. By this action we feel that there is less opportunity of trauma to the bladder and its supports. A large soft rubber catheter is easier to use than a small one and empties the bladder more quickly. Occasionally one is compelled to use a metal catheter, and one with a special curve was devised at Sloane Hospital.

Anesthesia is frequently given for vaginal examination with the whole hand, to verify the position of the head, and to "iron out" the perineum, not too forcibly, with tincture of green soap or liquid albolene, as Dr. Potter practices.

After first stage analgesia and intermittent anesthesia in the second stage there frequently occurs a lack of advance with the head low. It is one of the drawbacks of the relief of pain. For years Irving of Boston for this late inertia has utilized pituitrin, starting with one minim of a potent preparation, and if necessary repeating the dose every fifteen or twenty minutes, and increasing it up to a few minims only. If this has no result, prophylactic forceps may be used as advocated by De Lee.

THE HEAD ON THE PERINEUM

With the head crowning, the Ritgen maneuver is taught extensively and is helpful, but the compression of the perineum between fingers and head may produce as much damage as it prevents. Our preference is to rely mainly on the anesthetist to prevent too great uterine contraction, and to hold the head back gently. Pressure on the fundus with the head crowning will often overcome lack of advance,—a gentle modified Kristeller method. The obstetrician himself must do this, so as to use just the desired force, and no more and no longer than he desires. It is helpful to tuck the labia minora behind the occiput.

Episiotomy is frequently but not routinely performed, and surely if a laceration is seen to be a certainty. We favor the right mediolateral episiotomy, as being situated farthest from the rectum. Early episiotomy may prevent some cystocele, but there is the temptation to wait until the perineum is somewhat thinned out,

when it is easier to cut. Episiotomy undoubtedly spares the baby some punishment, as De Lee emphasizes.

The exaggerated lithotomy position with the thighs much flexed probably helps the head to get through the pelvis. The partial Walcher position relaxes the perineum and should be used late in breech presentations, forceps deliveries, and possibly in most cases as a routine. It is of some advantage to have a delivery table that will allow of these changes in position. Having the patient's extremities held by nurses is ideal, if the nursing department can supply the required personnel.

OCCIPUT POSTERIOR

What shall we do about occiput posterior positions of the head? In the male type of pelvis they should be allowed to deliver as such. Some schools adopt a policy of *laissez-faire*, realizing that in time many of them will rotate, but are ready to give more sedation to such patients.

Most prominent obstetricians rotate to occiput anterior when the cervix is fully dilated. There are many methods. Manual rotation is splendid, but the malposition often recurs. Pomeroy and Melhardo recommend pushing the head up out of the pelvis, rotating it with the shoulders and then allowing it to descend again with pains (Pomeroy), or (Melhardo) applying forceps to the floating head. Pro-lapse of the cord must be guarded against in these methods and probably will prevent their general adoption.

The modified Scanzoni rotation (1852) by double application of the forceps is the favorite method, as exemplified by Bill (1915, 1928). Here the solid blade forceps are used. A few of us follow Williamson's method, namely, manual rotation of the head to an occiput transverse position, in which position it is almost sure to remain until the Bailey-Williamson forceps (1926) can be used with a cephalic application (with rotation of the anterior blade as it is being inserted), and then rotation of the head to occiput anterior. Theoretically in all of the last methods the forceps should be removed and the patient allowed to deliver the head, but it seems more practical to complete the delivery by forceps.

FORCEPS

For occiput transverse positions of the head in high arrest the Barton forceps (1925) are indicated, or the Kielland forceps (1915). The last are used by some to rotate most occiput posterior positions.

Sometimes internal podalic version is the best way to terminate labor in the baby's interest, as when the cord prolapses, or the head is high.

In mentioning forceps, one should consider two of the newer forceps with axis-traction curves, the Hawks-Dennen (1931), and the Adair (1938). In using these forceps more progress is obtained with less effort than with ordinary forceps, and the blades are so fashioned as to injure the head less. With them one can pull in the long axis of the handles. They are not good rotating forceps. The axis tractor of Bill (1924) applied to a forceps gives splendid results.

In all deliveries, and especially in the application of forceps, it is necessary to know surely the position of the head by feeling sutures, fontanelles, the occipital protuberance, or if necessary an ear; the last especially if a large caput obscures other landmarks. Forceps blades should be applied exactly to the sides of the head and the anterior edges of the blades should be parallel with and equidistant, by about a finger breadth, from the lambdoid sutures; this brings the blades in front of the ears. The proximal ends of the fenestra should be just palpable between forceps and head. Between forceps tractions the fetal heart should be watched. Also one should rest at least twice as long as one pulls, and our electric timer aids in carrying out this dictum, when one changes the interval of the bell to one-half or one minute. The natural tendency is to pull too long and rest too little, as we had proved long ago.

THE DELIVERY OF THE HEAD AND SHOULDERS

After the delivery of the head one should promptly wipe material from the mouth and eyes without entering the mouth. The soft rubber or woven silk suction catheter can be used at this moment if necessary, especially if the shoulders stick. Its early use should be routine. The hole should be in the end of the catheter, not the side.

Feel for the cord about the neck; if found, slip it over the head, or clamp and cut if necessary.

In delivery of the shoulders there should be only slight to moderate traction on the head and only with the neck straight. Pressure on the fundus again will help to deliver the shoulders. We feel that one does not need to get a finger in the axilla to deliver the shoulder.

It is a tremendous mistake to hold back the head until a particular physician can arrive to deliver it.

BREECH PRESENTATION

For a breech presentation the best advice is not to hurry at any time; to give sufficient sedation; and perhaps to break up the impacted legs of a frank breech which does not advance. It seems to some of us wise to have a second physician of experience present at any breech delivery. Episiotomy should be done early, the thighs lowered, and the Piper forceps (1929) applied to the head if any difficulty is encountered. A retractor inserted posteriorly may allow the baby to breathe before delivery. The neck should be splinted with the middle finger when traction is used on the shoulders. The trunk must not be much extended over the mother's body, as formerly was advised.

The best treatment for a breech, however, may well be external version during late pregnancy.

THE EYES

Three matters we are tempted to speak of, even though they are used early in the third stage. In putting drops in the eyes the lids can be opened much more easily by small eyelid retractors than by the fingers and gauze. The retractors are placed on the outer surfaces of the lids and not under the lids, and result in less trauma and swelling of the eyelids.

Last year Skeel, of Cleveland, reported total elimination of gonorrheal ophthalmia by a modified technic, as follows:

"1. At the time of delivery of the head, the eyes are carefully cleansed with dry sterile sponges. No boric acid solution is used.

"2. When the cord has been cut, three or four drops of 0.5 per cent solution of silver nitrate are instilled, and the lids are gently manipulated to distribute the solution to every part of the conjunctival sac. After forty-five seconds the sac is freely flushed with a 20 per cent solution of mild silver protein. This irrigation is repeated on three successive days as a routine part of the nursery technic. The substance must be completely dissolved. The solution is prepared twice weekly.

"We think that the repeated conjunctival flushing with a bland silver preparation is vital to the success of the method.

"The occasional late infection which was observed before the use of repeated irrigations with bland silver solution occurred as the result of the presence of a few organisms of reduced virulence, which are destroyed by the successive treatments."

THE UMBILICAL CORD

The Kane umbilical cord clamp of 1934 seems so far superior to any other method or clamp that we feel justified in mentioning it. Removed in twelve hours, it leaves an exceedingly small dry stump.

THE DOCTOR HIMSELF

Let us close with a remark of the late Barton Cooke Hirst, that the best treatment of labor was to give the doctor one or two cigars, to prevent impatience. One can be patient if one is reasonably sure of the conditions present.

21 Plymouth Street

A LESSON FROM A DEATH CERTIFICATE NUMBER FOURTEEN

Patient sent to hospital one week before delivery. Diagnosis of placenta previa made on examination. No bed in hospital. Patient sent home to report to her physician when in labor.

Severe hemorrhage and patient died following delivery.

Is it safe to allow a placenta previa patient to go home?

A. W. BINGHAM, M.D., East Orange, N. J.

HISTORICAL ARTICLES

HISTORY OF THE CAMDEN COUNTY MEDICAL SOCIETY

Camden County was set off from Gloucester County by a legislative act dated August 13, 1843. The organization of the Medical Society of the county was authorized by The Medical Society of New Jersey on May 12, 1846.

On May 9, 1871, the twenty-fifth anniversary of the founding of the society was cele-

brated, and at that time Dr. Richard M. Cooper, of Camden, delivered an historical sketch of the society. This address has been published by the society as number one of a series of historical sketches of the society; and is reproduced in the following article.

ANNIVERSARY ADDRESS, MAY 9, 1871

By RICHARD M. COOPER, M.D., President, Camden, N. J.



Rich^d M Cooper

The Camden County Medical Society completes its first quarter century of active and useful existence this year. It is proper that an historical sketch of its rise and progress be given at this annual meeting. As your historian it is with feelings of pleasure, mingled with sadness, that I undertake this duty. I find myself the sole survivor of the group, commissioned on May 12th, 1846, who met on August 14th, 1846, in Haddonfield, to organize this Society. Each of my associates on that occasion has paid his debt to nature and passed from the active and busy scene of professional life to another and, we trust, better world.

For several years previous to 1846 the matter of organizing a County Society was dis-

cussed by physicians as they casually met. Living in distant and remote sections of the county there was little opportunity for meeting, except as they passed on the highway. However, they honored one another well by reputation. Occasionally there was an overlapping of practice and frequently an interchange of patients caused by their removal from one part of the county to another.

A petition was drawn up, signed by each of the legal practitioners of medicine in the county, and presented to the Medical Society of New Jersey at the annual meeting at New Brunswick in May, 1846. A legal practitioner, at that time, qualified by examination before the Board of Censors of a County Society. If successful, he was given a certificate of examination, signed by the censors, which he transmitted to the President of the State Medical Society, who issued a diploma, or license to practice, under the seal of the State Society. A fee of eighteen dollars was charged for this. Legal qualification was also one of the requirements for membership in a County Society.

A commission issued from the State Society authorizing the following physicians, to wit: Jacob P. Thornton, Richard M. Cooper, James S. Risley,* Charles D. Hendry, Othniel H. Taylor, and Issac S. Mulford, to meet "at the County Town on the 14th day of August at 10 o'clock in the forenoon" and organize a County Medical Society, subject to the rules and regulations of the State Medical Society and also subject to its approval. In accordance with this commission the aforementioned gentlemen, with one exception, met at the hotel of Joseph C. Shivers, in Haddonfield, on the day ap-

* In the Transactions of the State Society of May 12, 1846, the committee to found the Camden County Society was named; and in it James S. Risley was omitted and Dr. L. F. Fisler was named in his place. Two of the founders became Presidents of the State Society—Dr. Taylor in 1852, and Dr. Cooper in 1856.—*Editor's note.*

pointed (August 14th, 1846). Dr. Mulford, whose name was on the commission, was indisposed and unable to attend but joined us the next year.

The Society was organized by the appointment of the following officers: President, James S. Risley; Vice-President, Othniel H. Taylor; Secretary, Richard M. Cooper; and Treasurer, Jacob P. Thornton. At this meeting a constitution and by-laws were adopted which, with some modification, are the same under which we now act. The constitution and by-laws, together with the proceedings, were forwarded to the Standing Committee of the State Medical Society and were approved. Also, delegates were appointed to the semi-annual meeting of the State Medical Society at Hightstown on the second Tuesday in November. The delegates all attended this meeting and were most cordially received by the members of the State Medical Society, and the Camden County Medical Society was formally received into The Medical Society of New Jersey.

The next meeting of the County Society was held at Haddonfield on March 30th, 1847. Dr. Isaac S. Mulford was present and joined the Society. Dr. Mulford, with his well-known regard for strict construction, insisted that the first meeting at Haddonfield was a fatal defect in the organization and that the State Medical Society must be petitioned *de novo* and a new start made the next year.

The reason for this may be briefly explained. Camden County had been recently set off from Old Gloucester County. The courts of law met and the records were kept in the City of Camden, temporarily, while the inhabitants were authorized to hold an election to select the county seat. The outlying townships of the present Camden County opposed the separation from Old Gloucester County, while it was favored by the City of Camden. The contest for the location of the county seat was carried on for several years with a degree of acerbity that can hardly be appreciated at the present time. At the first election a large majority voted to locate the county building at Long-coming,* although there was no railroad communication with that town until many years later.

It was during this contest that our Society was organized. Drs. Risley and Hendry, who had charge of the petition for the formation of the County Society, designated Haddonfield as the meeting place. Needless to say, they were both violent anti-Camden men.

After Dr. Mulford's criticism the whole

matter was referred to the Standing Committee of the State Medical Society at its next meeting. This committee, after examination of the subject, decided that in the absence of a permanent county seat, the meeting held in Haddonfield, though rather informal, did not vitiate the proceedings and that our Society was regularly organized.

The third meeting of the Society was held at Camden on June 18th, 1847. At this meeting it was ordered that the annual meetings be held at Camden on the third Tuesday of June and the semi-annual meetings be held on the third Tuesday of December at such place as the Society should direct.

A Board of Censors for Camden County was appointed at the preceding meeting of the State Medical Society. A number of physicians came before this Board for examination. Those who were licensed and resided in Camden County were elected members of the Society. Almost every year since that time our Society has received additions to its membership from amongst those who have entered upon the practice of the profession in our county.

Also at this meeting it was resolved that the names of all the regularly licensed physicians in Camden County should be published in the newspapers, together with the twelfth section of the State Medical Society charter. This section listed the penalties incurred by those who practiced without license of the State Medical Society. This publication aroused a violent opposition from those whose names were not on the list, as well as from the Homeopaths and Thompsonians, of whom there were a few in the county.

This feeling of opposition ventilated itself by long articles in the newspapers, directed against the County Society as well as the State Law. Among others, the Society became involved in a controversy with the late Dr. Lorenzo F. Fisler, whose name was not on the list. It may not be out of place to allude to this matter as it was the cause of no little stir both in the profession and community.

The old charter of the State Medical Society expired by limitation in 1815 and it was not renewed until the following year. In the renewed charter a section was incorporated which permitted all physicians who were *bona fide* practitioners at the time of its passage to be considered as legal practitioners without the necessity of examination.

Dr. Fisler claimed exemption under this section of the renewed charter on the ground that he was practicing at the time (1815) at Port Elizabeth, in Cumberland County. He was graduated from the University of Pennsyl-

* Present Berlin.

vania Medical School in 1818. This claim was refused by the Board of Censors of Salem County on the ground that the doctor was a pupil in his father's office and not a *bona fide* practitioner. Dr. Fisler continued to practice at Port Elizabeth and in 1825 qualified before the Board of Censors of Salem County after an examination. The doctor often informed us that this examination was very severe because of the enmity of some of the censors. He was granted a certificate of satisfactory examination which entitled him to a license on its presentation to the President of the State Medical Society. This the doctor refused to do and the certificate was thrown aside and, in the lapse of years, lost.

So the matter rested and Dr. Fisler removed to Camden in 1837.

When his name was omitted from the published list of licensed practitioners he was aggrieved greatly and came out in the Camden papers with a long communication against the County and State Societies. In this letter he mentioned the old controversy with the Board of Censors of Salem County. He was also specific in mentioning one of the censors, Dr. Charles Hannah of Salem County, with whom he had some disagreement.

This publication was deemed of sufficient importance to call a special meeting of the Society in order to formulate a reply, which was done. In it, allusion was made to a letter from Dr. Hannah to the Society in which Dr. Hannah stated that Dr. Fisler had never qualified before any Board of Censors of which he was a member. He went on to say that he was a member of every Board of Censors that had ever met in Salem County. He still further remarked that if his name was on any certificate of examination of Dr. Fisler it was without his knowledge or consent.

Thereupon, Dr. Fisler went down to his father's residence in Port Elizabeth and found the original certificate of examination dated in 1825 and signed, among others, by Dr. Hannah. This he brought back to Camden and exhibited to members of our County Society. At the same time he started a libel suit against Dr. Hannah. Through the inter-position of mutual friends, Dr. Hannah, who was very old, made every apology and the affair was amicably settled. The State Medical Society granted Dr. Fisler a license upon presentation of the certificate. However, he ever after held aloof from the County Society and, although frequently solicited, declined to become a member.

From this time the career of the Camden County Medical Society has been peaceful and prosperous. At almost every annual meeting

the Society has received additions to its membership from among the younger members of the profession. These gentlemen, on commencing practice, complied with the medical law of the State and obtained a license from the State Medical Society. The law requiring an examination before a Board of Censors was amended in 1851. The amended law authorized the licensing of graduates of a large number of medical colleges, named in the amendment, upon the exhibition of their diplomas to the President of the State Medical Society. A license to practice was thereupon issued which became effective when it was recorded in the County Clerk's Office and a fee of five dollars paid.

One section of this amendment of 1851 authorized the State Medical Society, on the complaint of any district Society, to revoke the license of anyone guilty of malpractice or gross violations of the rules of the Society. The person so charged was to have due notice so that he could make a defense.

Under this section of the law a charge was made against a notorious violator and maker of quack medicines who was located in Trenton. He failed to make any defense and his license was revoked. This individual managed, in the closing days of the next session of the Legislature, to have an Act passed. This Act, passed without the knowledge of the State Medical Society, authorized the graduate of any medical college to practice by recording his diploma in the county in which he resided.

Although the functions of the State Medical Society were in no other way interfered with, this Act eliminated its authority as a licensing body. However, most of the County Societies, including our own, still required the State Society diploma as an essential for membership. Despite the new Act a considerable number of diplomas were granted by the President of the State Medical Society each year.

At the annual meeting in 1851 a committee of three was appointed to prepare a census of all practitioners of medicine in Camden County. The committee reported at the annual meeting of 1852, that there were twenty-seven persons practicing medicine in Camden County. Twenty-five of these were graduates of respectable medical colleges, of whom one was a homeopathist licensed under the Law of 1851. Two were botanists or herb doctors, making no claim and entitled to none of the privileges of regular physicians. It will be seen that, at that time, the great body of the profession in Camden County were licentiates and in affiliation with the State Medical Society. It would be well to repeat the census this year as it is the termination of the di-cennial period. In

1851 the semi-annual meetings of the Society were discontinued.

In 1865* The Medical Society of New Jersey, then approaching its centennial, petitioned the Legislature to reorganize on a voluntary basis, surrendering its special privileges. It was thought, in view of the constant meddling of the Legislature with our chartered privileges, that it would be best to give them up. As a result of the petition an Act to reorganize The Medical Society of New Jersey was passed. This Act was perfectly satisfactory to the State Society, retaining all the powers it was thought desirable to hold, and abolishing the right of licensure except the granting of diplomas after a professional examination. As a matter of fact, the bill was drawn up by a committee of the State Medical Society, of which your historian was a member. The Act, which went into operation at the centennial meeting of the State Society at New Brunswick on the fourth Tuesday of January, 1866, required every member of a district society to be a graduate of a respectable medical school in affiliation with the American Medical Association.

In 1867, the time of the annual meeting of the County Society was changed to the second Monday in May. This was done to conform to the annual meeting of the State Medical Society, which was changed from the fourth Tuesday of January to the fourth Tuesday of May. Our Society has held regular meetings each year since its organization in 1846. It has brought the members of the medical profession into more intimate personal as well as professional contact and thus fulfilled one of the objects of its organization. Through its standing committee it has presented a summary of the diseases of each year, a history of the diseases which we have been called upon to treat, and a description of many cases of rare interest occurring in the practice of its members.

It has included in its roll of members the names of nearly everyone who has entered the practice of medicine in Camden County since

its origin. A few, residing at a distance, have ceased to attend, giving as a reason the want of time to leave their practice. However, we are glad to say that some of our most active, as well as most punctual, members are those who live farthest from the meeting place.

Since our first meeting in 1846, some forty-two members have been enrolled. Two, Drs. Bartholomew and Record, were expelled for embracing Homeopathy. Dr. B. W. Blackwood practiced that system after resigning his membership. With these exceptions all of our members have remained loyal to their diplomas.

At the present time (1871) we have a membership of twenty, including three honorary members. The list is as follows in accordance with the date of joining the Society:

Richard M. Cooper	1846
Isaac S. Mulford	1847
A. D. Woodruff	1847
John V. Schenck	1848
John W. Snowden	1849
Thomas F. Cullen	1850
Richard E. Dean	1854
N. B. Jennings	1855
H. Genet Taylor	1860
Henry E. Branin	1860
I. Gilbert Young	1863
John R. Stevenson	1863
Alexander Marcy	1864
Joseph F. Garrison	1865
James M. Ridge	1866
J. J. Comfort	1866
Alexander Mecray	1867
J. Orlando White	1868
D. W. Heulings, Jr.	1870
R. W. Morgan	1870

In conclusion, we can today congratulate ourselves that our Society is in active and useful existence. We may look forward to many years of useful activity to the community and the profession. May we hope that at our semi-centennial anniversary some abler pen will give a retrospect of another twenty-five years of continued prosperity and usefulness.

RICHARD M. COOPER, M.D.

Dr. Richard M. Cooper belonged to a family whose ancestors settled in Southern New Jersey in 1678, and whose members were noted for intelligence, refinement, and wealth. He bore the name of his father, who was Presiding Judge of Gloucester County, member of Congress, and president of a leading local bank.

Dr. Cooper was born August 30, 1816. He graduated from the literary department of the University of Pennsylvania in 1836, and from its medical department in 1839. He practiced medicine in his native city for thirty-five years, and died May 24, 1874.

The addendum to Dr. Cooper's historical sketch of Camden County, which is reprinted in the preceding article, contains an appreciation of the author's life and career as follows:

* Committee was appointed January 27, 1863, and reported January 2, 1864. The law was approved March 14, 1864, to take effect on January 23, 1866.—*Editor's note.*

Dr. Cooper was a member of the State Medical Society, serving as the seventy-first President in 1856. He was interested in the American Medical Association and, on occasion, served as delegate to its meetings.

He was one of the founders of this Camden County Medical Society and served as the first Secretary. He repeatedly refused the presidency, saying that the younger members should be elected to this office so that their interest in the Society might be stimulated. In 1871 he was elected President.

He was active in organizing the Camden City Medical Society which, after years of useful existence, was absorbed by the County Society. He also helped to found the Camden City Dispensary.

He was interested in civic affairs. To quote from Stevenson's history, "Dr. Cooper was never indifferent to his responsibility as a citi-

zen, and it was this that led those who knew him best to seek his advice and counsel when matters of public interest required the mature deliberations of one so prudent, unselfish, and discriminating."

And further from the same history, "Professionally, Dr. Cooper appears to have attained almost the station of the ideal physician, for he had a broad love for humanity as well as an enthusiasm for the healing art. * * * A man cast in such a mold would naturally find pleasure in forwarding works of charity and benevolence."

His influence with his family was such that after his death they bequeathed their estates to found the hospital which bears their name. This is a material monument to Dr. Cooper's idea of usefulness. The enduring monument is the spirit that is transmitted to each of the physicians who follow Dr. Cooper.

THE SEAL OF THE MEDICAL SOCIETY OF NEW JERSEY

The use of a distinctive seal by official medical societies was formerly popular and almost universal. At present a seal is used by the American Medical Association; by eleven State Societies, including that of the District of Columbia; and by eleven county societies of New Jersey.

A seal for The Medical Society of New Jersey was first proposed at the annual meeting on November 7, 1786, as is recorded in the following entry in the minutes (Transactions, Vol 1, page 51):

"Ordered, that a seal be made for the use of the Society; and that Dr. Smith, Dr. Wiggins, and Dr. Beatty be a committee to procure said seal, and affix what device they think proper."

The committee consisted of three Past Presidents of the Society, who reported progress from time to time. A seal seems to have been adopted on May 4, 1790, and an embossing press was secured.

The seal, with some alterations, was again adopted on June 13, 1816, on recommendation of another committee of Past Presidents. This is the seal which is still used by the Society.

The seal was frequently printed in the records of the Society, sometimes two or three inches in diameter. It was often printed with a black background, on which the device and inscription appeared in white, like the negative of its photograph; and sometimes it was

printed in black lines on a white background, as it is today.

The original seal was frequently printed on the title page of the annual volumes of the Transactions; and it has been printed on page one of each issue of The Journal, the first number of which appeared in September, 1904.

The original seal did not bear the name "The Medical Society of New Jersey" in English words; and therefore these words were added in conspicuous type encircling the seal. This form of the seal has been printed on the bottom of the cover page of each issue, beginning with that of January, 1936.

An interpretation of the meaning of the seal was printed as an editorial in The Journal of August, 1934, page 444, as follows:

The seal represents the oracle in the Temple of Apollo, the supreme god of health and vigor. The High Priest is shown delivering a prophesy as he stands beside the altar. High above him shines the clear light of inspiration. The Latin inscription above the columns is a line from the Latin poet, Ovid, and may be translated "A bearer of good works around the world am I called".

The inscription on the altar is an abbreviation for "Cortina merces anti", which may be translated "The oracle of Apollo is opposed to commercialism"—Cortina being the technical name for the oracle of Apollo.

The inscription below the altar may be translated "New Jersey Medical Society Seal".

STATE SOCIETY ACTIVITIES

COMMITTEES SUBSIDIARY TO THE WELFARE COMMITTEE

The dates of four scheduled meetings of the Welfare Committee and its four sub-committees were announced in *The Journal* of July, 1939, page 407. In accordance with that program, five meetings were held on Sunday, October first, in the Executive Offices and adjoining rooms. Each of the sub-committees met at eleven o'clock and discussed its own program, and those of its advisory committees. After a noon luncheon had been served in the Executive Offices, the sub-committees met at

two o'clock and reported their programs at a general meeting of the Welfare Committee. An outline report of this meeting was printed in *The Journal* of October, page 613.

After a general meeting, the chairman of each of the four sub-committees prepared a summary of the program of his committee, and of the programs which had been submitted by the chairman of each of its advisory committees. These programs are printed in the articles which follow.

A. THE SUB-COMMITTEE ON PUBLIC HEALTH

STANLEY NICHOLS, M.D., Asbury Park, N. J., Chairman

A meeting of the Sub-Committee on Public Health was held on October 1, 1939, at 11 o'clock in rooms adjoining the Executive Offices at 143 East State Street, Trenton, N. J. Those present were Dr. Stanley Nichols, Chairman, and Drs. Lathrop, Bingham, Dilger, Levy, Jaffin, Blaisdell, Ireland, Murphy, Sewall, Morris, and Frankel.

Guests present were Drs. Cronk, of Middlesex County, and Thalheimer, of Cumberland, and Mr. William H. MacDonald, Chief of the Bureau of Local Health Administration of the State Department of Health.

Chairman Nichols asked that each advisory committee appoint a vice-chairman.

The Sub-Committee on Public Health gave a report to the Welfare Committee at two o'clock on October 1, 1939, which was printed in the October *Journal*, page 614. Dr. Stanley Nichols, Chairman, has supplied the following list of the objectives of the sub-committee and its advisory committees:

PROGRAM OF THE SUB-COMMITTEE

1. To coördinate the Advisory Committees affiliated with the Public Health Committee and to articulate better the activities of these committees.

2. To discuss and evaluate reports of the Advisory Committees.

3. To act as a clearing house for imparting up-to-date information to members of the Society.

4. To study the final report of the Governor's Health and Welfare Conference.

Each advisory committee then submitted its program for the year in an orderly outline of numbered paragraphs.

1. MATERNAL WELFARE

Chairman Arthur W. Bingham submitted the following twelve-point program of the Advisory Committee on Maternal Welfare:

The Committee on Maternal Welfare of The Medical Society of New Jersey in cooperation with the Bureau of Maternal and Child Health of the State Department of Health reports its program as follows:

1. The community hospital. (Read July *Journal*, page 439.)

2. Regular obstetrical conferences open to all physicians.

3. Lecture courses.

4. Refresher courses.

5. Field physicians. (Paid for by Department of Health.)

6. Investigation of maternal deaths. (Paid for by Department of Health.)

7. Study of annual obstetrical reports of hospitals.

8. Nursing delivery service and consultation service. (Paid for by the Department of Health.)

9. Systems for prenatal care.

10. Statistical study. (Read August Journal Maternal Mortality charts, pages 510-516.)

11. A maternal welfare article in State Medical Journal each month.

12. A lesson from a death certificate in State Medical Journal each month.

Comment:

Chairman Bingham announced that a major objective of the committee will be to record the details of every obstetrical case in the hospitals of the State. In order that the records may be complete in every detail, his committee had planned a book of blank sheets over two feet in length, ruled for spaces in which each item of the obstetric conditions of each case can be recorded by the physician and nurse. The sheets have already been designed, and an estimate made of their cost when they are bound in book form, ready to be presented to each hospital.

The detailed records in books will be invaluable sources of information regarding the procedures and their results in every obstetric patient in every hospital in the State. Its unique value will be that all the records will be made on a uniform basis, whose results will be of the greatest possible value along two lines:

1. The items will be reminders to the attending physicians and nurses concerning the details to be observed and followed in every case.

2. The records over a series of years may be utilized in evaluating the results of specific procedures carried out over a series of years by independent obstetricians throughout the entire State of New Jersey.

It was proposed that the coöperation of the Hospital Association be secured in printing the books and keeping the records.

Dr. Julius Levy, for the State Department of Health, announced that the *Field Physicians* had been reappointed, and their work coördinated throughout the State. By their work the facilities of both the State Department of Health and the Medical Societies of the State and the several counties will be made available to physicians of every part of the State in their private practice.

2. CHILD HEALTH

Chairman Stanley Nichols stated that the objectives of the Committee on Child Health during the coming year would be:

1. To continue action on the 1938-39 program.

2. All counties to make a study on Child Health similar to that made by Essex.

3. The committee to assist in a study now being made by the Bureau of Child Hygiene of State Department of Health on the "Care of Prematures in New Jersey".

4. The committee to coöperate in a study of "Deaths in Babies in the First Month", in conjunction with Bureau of Child Hygiene of State Department of Health, and the American Academy of Pediatrics.

5. The committee to promote with Maternal Welfare Committee "Breast Feeding in Infants".

6. To secure a more active participation in the examination of the school child by the family physician.

Comment:

Dr. A. G. Ireland reported that an effort was being made to promote the participation of the family physician in examinations of the school child. Five school superintendents have been contacted with the request that a conference be held with their medical staffs and a representative of the county medical societies, and three favorable replies have been received.

New Board of Education rules permit the Board to require tuberculosis tests of any or all pupils. Diphtheria immunization, which has been done for many years, may be required as a requisite for attendance at school. The removal of clothing during examinations is permitted in special cases, but the parents of the child must be notified and asked to be present. Another Board rule requires a health examination of all employees, including teachers, once in every three years.

The Department of Education will invite representatives of the State Medical Society, the Department of Health, the Tuberculosis League, and the Health and Sanitary Association to meet in a conference to discuss regulations and standards for physical examinations.

3. TUBERCULOSIS

Dr. A. E. Jaffin, Chairman of the Advisory Committee on Tuberculosis, announced that the objectives of the committee during the present year will be:

1. To give a post-graduate course on the modern concepts of tuberculosis and case-finding methods, once a year in each county.

2. To carry out plans for case-finding in adult groups.

- a. X-ray all adults in private practice as a part of periodic health examination.
- b. Urge chest x-ray of all hospital admissions.

- c. Urge fluoroscopic or x-ray examination of all prenatal cases.
3. Extension of surveys of high school students, and other adolescent groups.

Comment:

It was suggested that post-graduate courses be set up so that each man may thoroughly understand the dual rôle he should play,—that of a public practitioner as well as a private practitioner. We can go no faster in public health work than we can educate the doctor to take part in this work. This must be done without incurring the ill will of the private practitioner.

To this end, Dr. Nichols presented the following resolution:

Be it resolved, that, in order to further improve the quality of medical service rendered to the public by the members of The Medical Society of New Jersey, the Post-Graduate Education Committee, the Committee on Medical Practice, the Public Health Committees of the State and County Societies and the Executive Officer and his staff, shall, with the help of the State Department of Health, in the State and in each county, create a continuous permanent program of *post-graduate education* in each of the fields of preventive medicine and public health carried on by this Society; to the end that there may be made available to every physician in this Society, in his own county, all possible facilities for the improvement of his knowledge in each of these preventive medical and public health fields, for use in his practice.

Dr. Blaisdell moved that the resolution be adopted by the Public Health Committee and presented to the Welfare Committee for its consideration. The motion was seconded by Dr. Jaffin and unanimously carried.

4. VENEREAL DISEASES

Chairman C. Byron Blaisdell stated that the objectives of the Advisory Committee on Venereal Disease would be:

1. To continue the four points of the 1939 annual report.
2. To outline the principles in the control of venereal disease infections, and to define term "infection".
3. To standardize laboratory tests for typing in order to insure greater uniformity of the reports.

Comment:

Dr. Blaisdell asked that the Public Health Committee approve a program to be developed jointly by the State Medical Society, the Society of Clinical Pathologists, and the State

Department of Health, for the purpose of standardizing laboratory tests, so that there can be no uncertainty in the diagnosis of cases of venereal disease. The following resolution proposed by Dr. Blaisdell was adopted:

Whereas, a physician sending the same blood to three different laboratories to be tested for syphilis may receive one positive, one doubtful, and one negative report; and

Whereas, these differences are due mainly to differences in sensitivities in the methods of testing; and

Whereas, the U. S. P. H. S. has shown in its evaluation studies that the better laboratories can produce relatively uniform results in their tests; and

Whereas, the State Health Department has facilities for supplying standardized syphilitic serum to all serologic laboratories; therefore be it

Resolved, that the New Jersey State Medical Society adopt a standard sensitivity for tests for syphilis in cooperation with the New Jersey Society for Clinical Pathologists, and the State Department of Health Laboratory; and also such methods for reporting as will assure physicians of receiving approximately similar and accurate reports from all cooperating laboratories.

5. ADULT HEALTH SUPERVISION

Dr. Herschel S. Murphy, Chairman of the Advisory Committee on Adult Health Supervision, submitted the objectives of his committee:

1. Monthly communication to county societies urging the advantages of periodic health examinations, and emphasizing use of report forms supplied by Society.
2. Distribution of "Key to Long Life" by physicians through their offices.
3. Publicize and stress importance of annual physical examination through county societies.

Recommendation: " * * * that each doctor in the State send a card to his patients on their birthdays reminding them of their birthday, and of the importance of an annual birthday physical examination."

Request: " * * * that a set of physical examination forms together with a copy of 'Key to Long Life', and a birthday card, be sent to each member of the Society during month of September."

Comment:

The Medical Society has prepared cards and letters to be sent as reminders to the patient that it would be advantageous to have a physical examination. An adult health physical examination form has also been prepared by the Society, but it is rather expensive; and as an alternative it was suggested that the single

sheet examination form prepared by the A. M. A. be used.

The Adult Health Committee would like to send pamphlets rather than letters as reminders, but this also has been thought too expensive. Dr. Murphy suggested that pamphlets telling of the advantages of periodic examinations be sent to the doctors to be placed on their waiting room tables for the patients to read.

6. CRIPPLED CHILDREN

Dr. Elmer P. Weigel submitted the following four points as the objectives of the Committee on Crippled Children, of which he is chairman:

1. To coöperate in every way with the Crippled Children's Commission concerning the care of all cases.

2. To try in every way to keep the care of these children, as nearly as possible, in the hands of local doctors when such men are available.

3. To make an effort to survey the facilities available in the various institutions of the State for the after-care of crippled children.

4. In a general way, to preserve the relationship to the doctor which has existed in the past, rather than permit encroachment upon the initiative of the individual doctor.

7. TRAFFIC ACCIDENTS

Dr. Millard F. Sewall, Chairman of the Advisory Committee on Traffic Accidents, reported that the committee had met and considered various phases of the problem of automobile accidents. However, since the committee was comparatively new, it had not yet completed its survey, but would submit its suggestions as soon as it could formulate them.

Last week Dr. Sewall met with Commissioner Magee, who offered several suggestions to the committee for consideration. Mr. Magee would like to have individual doctors coöperate on all pathological findings in cases of automobile accidents, as well as cases of slumping at the wheel, in order to determine the possibility of these being the cause of the accident. He suggested that doctors call to the attention of the Department of Motor Vehicles any physical conditions which might require a special examination at the issuance of license. The Department would like to have information relative to physical conditions which might be contributing factors in accidents. Mr. Magee has complete authority to enforce any regulations resulting from our suggestions.

It was suggested that a copy of the "Drunk-en Driving" form, which was presented to the

Department last year, be printed in the State Society Journal.

8. CONSERVATION OF VISION

Dr. Elbert S. Sherman, Chairman, announced the program of the Advisory Committee on the Conservation of Vision as follows:

I. Education of the public, especially in reference to:

- a. Pre-school ophthalmic examination of children;
- b. Establishment of additional sight-saving classes;
- c. Eye physicians and optometrists;
- d. Importance of early recognition of insidious (non-refractive) disease of the visual apparatus by eye physicians, and their relation to general disease.

These objectives are to be effected largely through coöperation with the Committee on Public Relations.

II. Education of the profession:

- a. Publication of papers in the State Journal;
- b. Talk to the county societies, hospital meetings, etc.;
- c. Work through the county societies by specially appointed or specially charged committees in liaison with this committee.

III. Full coöperation with the State Commission for the Blind in certain purposes for which our help has been asked; and also with the Bureau of Child Hygiene in respect to certain administrative work programs.

9. CANCER CONTROL

A meeting of the Advisory Committee on *Cancer Control* was held on Sunday, October 15th, 1939, 11:00 a. m., in the Executive Offices, Trenton, New Jersey. Those present were Dr. William G. Herrman, Vice-Chairman, who presided; Drs. A. S. Knight, Joseph H. Kler, O. R. Holters, T. J. Summey, and F. E. Keir; and Dr. W. T. Knight, Chairman of the Hackensack Tumor Committee.

Dr. Herrman read Dr. Orton's report of the Cancer Control Committee as printed in the 1935 annual reports, the report of the committee for 1939 which is printed in the May issue of the Journal, and the section pertaining to the "Cancer Control Program recommended by the committee" contained in the Preliminary Report of the Sub-Committee on Cancer of the Committee on the Expansion of Public Health, New Jersey Health and Wel-

fare Conference. A corrected copy of the latter report read by Dr. Herrman will be sent to each member of the committee to study, with the request that he come prepared to the next meeting, which will be held within the next month, with concrete suggestions and recommendations for the program of the coming year.

The subject of the Field Army, or other lay groups, taking up activities in the State as a whole was brought to the attention of the members. It was recommended by all members present that activities by lay groups of

any kind should proceed only by the approval of the County Medical Society within whose territory they plan to operate.

WILLIAM G. HERRMAN, M.D.,

Vice-Chairman,

Advisory Committee on Cancer Control.

10. PNEUMONIA CONTROL

The plans of the Advisory Committee on Pneumonia Control are set forth in the annual report of the committee, which is printed on page 305 of the Journal of May, 1939.—Editor's note.

B. THE SUB-COMMITTEE ON MEDICAL PRACTICE

DAVID B. ALTMAN, M.D., Atlantic City, N. J., Chairman

A meeting of the Sub-Committee on Medical Practice was held on Sunday, October 1, 1939, in the Executive Offices, Trenton, N. J. The meeting was opened at 11 a. m., with Chairman Allman presiding. Those present were Drs. Allman, Comando, Ulmer, Johnsen, Sharp, Fort, and Zehnder; and Dr. Wilkes, Secretary.

Chairman Dr. David B. Allman welcomed the hold-over members of the committee back again this year, and Dr. Johnsen, who is the new member. Dr. Allman felt the work this year should be easier for all because of better acquaintance among the members, and better familiarity with the work to be done. The next meeting will be held on Sunday, December third, at 11 a. m. in the Executive Offices.

PROGRAMS OF THE ADVISORY COMMITTEES

The advisory committees reported their programs, as follows:

1. AUXILIARY MEDICAL SERVICES

Dr. Sigurd W. Johnsen, Chairman, reported that the Advisory Committee on Auxiliary Medical Services had adopted the following objectives:

1. Promote public health by extending auxiliary medical services, including x-ray, laboratory, anesthesia, and physio-therapy measures.
2. Preserve private practice.
3. Study hospital practices throughout the State, and recommend remedial measures where they are needed.

Comment:

Dr. Johnsen announced that the State Society had never issued an approved plan for the

operation of the various departments of hospitals. He suggested that his committee this year study the departments of x-ray, physiotherapy, anesthesia, and laboratories of the hospitals throughout the State, with the object of formulating standards to be approved by the State Society and presented to the New Jersey hospitals as model departments for their consideration.

The Medical Practice Committee approved this objective, and Dr. Johnsen was instructed to work up a tentative plan and report it at the next meeting.

2. INDUSTRIAL HEALTH AND HYGIENE

Dr. J. Irving Fort, Chairman of the Committee on Industrial Health and Hygiene, reported the following activities to be sponsored by the committee:

1. To study the medical service set-up in industry, including the professional care, nursing service, and medical service stations in private plants, and also industrial clinics under the control of the government, or insurance companies.

Comment:

The A. M. A. has requested the names of all men doing full or part-time industrial work. On the committee this year are two men connected directly with industrial work, and this objective has been assigned to these two men who have access to the records and can obtain the information easily.

2. To study the existing regulations of both the Department of Labor and the State Department of Health as they apply to industry. This includes factory inspection, sanitary re-

quirements, safety rules, reportable diseases, and diseases peculiar to certain industries.

3. To study the advisability and the feasibility of preemployment physical and mental examination of employees.

4. To study the more common industrial diseases which are not at present included in the list of compensable industrial diseases, with the object of making them compensable.

Comment:

This fourth objective strikes a snag because many doctors working for insurance companies think we should soft-pedal the idea, because it will put more expense on the insurance companies.

5. To find a method by which physicians of the State may obtain post-graduate instruction in industrial diseases.

Comment:

Last year it was found that many diseases peculiar to many industries about which the general practitioner knows nothing were being investigated in the industrial laboratories at an expense of many thousands of dollars.

6. To obtain a survey of the incidence of accident and disease, with the idea of obtaining data on the most common diseases and accidents.

7. To coöperate with the A. M. A. Council on Industrial Health in obtaining information which will benefit our State, and will assist it in supplying data.

8. To hold joint meetings with other organizations in the State which are directly interested in the problems of industrial health and hygiene.

Comment:

This last objective is for the purpose of keeping ourselves up-to-date, and not allowing any other organization to get ahead of us. The industrial surgeons have prepared a questionnaire to send to all industries. The information we can obtain from them will be very useful to the committee. The committee this year is also working for complete and thorough co-operation with the Department of Labor.

Dr. Fort announced he has been accepted as a member of the New Jersey Society of Industrial Surgeons, although he is not an industrial surgeon, so that he can attend meetings of the Society and learn the viewpoints of its members.

3. WORKMEN'S COMPENSATION

Dr. Harry N. Comando, Chairman of the Committee on Workmen's Compensation, reported that the committee had adopted the following objectives:

1. Continuation of last year's work.
2. Reconcile any differences amongst any groups in our own Society.
3. Obtain opinions of other groups toward any changes in present compensation law.
4. Induce the Department of Labor to present a bill and incorporate the four major objectives of the Workmen's Compensation Committee of the Medical Society as expressed at the last annual meeting. (Annual report, Jour., May, 1939, p. 292.)

Comment:

As a result of a meeting on July 30 at which there were representatives of industry, it was found that the objectives of the industrial surgeons and the Medical Society in relation to compensation were not so far apart. There is general agreement that the shop doctor should continue in his work of taking care of injured employees of his own plant; however, the clinics which the insurance companies selling protection are setting up should be put out of business.

The committee has two main objectives in relation to the law:

1. A broadened definition for compensable hernia.
2. Separation of the hospital bill and the doctor's charge.

Two meetings have been held during September by the committee, the State Society Trustees, and representatives of the industrial surgeons. Another meeting is being planned with the Commissioner of Labor or his representatives, to get the Department to include these changes in the revision of the Compensation Act. Dr. Wilkes has been appointed liaison officer between the Compensation Committee, the Trustees, and the industrial surgeons.

Dr. Fort stated that plant clinics should be encouraged because:

1. They are vital and necessary to industrial hygiene and health in that they must protect their employees against hazards for which the company is liable.
2. They are training stations and can develop industrial physicians who will be exceptionally able to take care of extreme cases, and who can act as consultants to the physicians of other plants.

The Medical Practice Committee supported Dr. Fort's statement.

4. PHARMACEUTICAL PROBLEMS

Dr. Chester I. Ulmer, Chairman of the Committee on Pharmaceutical Problems, reported that the committee had adopted the following objectives:

1. To maintain and improve the ethical and friendly relationships between physicians and pharmacists. The closely woven interests of the two professions require harmonious co-operation, and mutual understanding.

2. To acquaint physicians with the New Jersey Formulary, and its ethical formulas. Its frequent use will overcome the tendency to write prescriptions for certain proprietary preparations. Many physicians prescribe over-priced, brand-controlled proprietary products.

3. Consideration of methods to eliminate some of the patent-medicine ballyhoo over the radio.

Comment:

We have already sent copies of a resolution to the broadcasting companies, "protesting against the prescribing of medicines and the giving of medical advice on the radio, with the exception of such broadcasts on health matters which are given under the auspices of recognized associations of licensed physicians or Federal, State, and local Health Departments".

Copies of the radio broadcasting resolutions have also been sent to other State Societies, with the request that broadcasting stations in their states be sent such a resolution. Some states have done this.

4. The committee advocates social meetings each year between the medical and pharmaceutical groups in each county in order to establish better acquaintances and friendliness between the doctor and the druggist.

5. NURSING AND NURSING EDUCATION

Dr. A. Charles Zehnder, Chairman, reported the following objectives of the Committee on Nursing and Nursing Education:

1. Meet any of the problems that might arise during the year.

2. Consider the possibility of using the Teachers' Training Colleges as places in which the didactic training of the graduate nurse could be given.

3. Cooperate with the New Jersey Nursing Association in solving any problems that might arise.

6. MEDICAL CARE OF THE INDIGENT

Dr. George W. Fithian, Chairman, reported that the Committee on Medical Care of the Indigent proposed the following:

1. A uniform system of relief, similar to the old Emergency Relief Administration, for the indigent group.

2. Voluntary health insurance for the low-wage group.

Comment:

In the absence of Dr. Fithian, Dr. Wilkes stated that the report of the Medical Care of the Indigent Committee of the Governor's Conference on Health and Welfare had recommended to the Executive Committee the re-establishment of a plan for medical care similar to the old E. R. A. plan. The final report of the Governor's Conference will be available some time during October, and he had recommended to Dr. Fithian to withhold any plans on the part of his committee until after the committee had read the recommendations of the Conference on this subject.

In regard to voluntary health insurance—the Medical Service Plan of New Jersey has been incorporated in this State, and the necessary legislation for the operation of the Plan is now being drawn up for introduction into the 1940 Legislature.

7. CONTRACT PRACTICE

Dr. Reuben L. Sharp, Chairman, reporting for the Committee on Contract Practice, stated that the A. M. A. has ruled that contract practice per se is not unethical. The committee has carried its work as far as it is able, since the Society cannot make a statement as to what is a good contract and what is not. The Society is merely interested in seeing that good medical care is given under the contract.

Dr. Zehnder expressed the opinion that, even though the committee had completed its work, it might be wise to continue it in a reference capacity in order to consider any disputes which might arise on the subject of contract practice. The existence of such a committee would also tend to keep physicians under contract in line.

The Medical Practice Committee instructed Dr. Sharp to inform the members of his committee that the committee would hereafter act as a reference committee to which any disputes on contract practice would be referred.

The chairman announced the date of December 3rd, 1939, 11 a. m., for the next meeting of the Medical Practice Committee, in the Executive Offices.

8. HOSPITAL RELATIONSHIPS

A meeting of the *Advisory Committee on Hospital Relationships* was held on Thursday, October 19th, 1939, at 5:00 p. m. at the Academy of Medicine, Newark, for a discussion and formulation of a program for the coming year.

Those present were Dr. S. T. Snedecor, Chairman, who presided; Dr. H. B. Decker, Dr. E. H. Snively, and Dr. Norman M. Scott, Executive Assistant.

The following tentative program for the year was formulated:

1. That this committee hold joint meetings with members of the New Jersey Hospital Association for a general discussion of the problems involved in hospital relationships, and steps to be taken in the solution of these problems.

2. That the committee continue consideration of the problem of staff organization, and that the committee make recommendations relative to this problem to be included in the constitutions and by-laws of the hospitals of New Jersey. These suggestions have to do with organization and relationships between the professional staffs, administrative staffs, and governing boards.

3. That the committee sponsor a survey of out-patient service activities and out-patient departments in a group of hospitals to be selected, to determine:

- a. The possibility of improving the standards of professional care in out-patient departments.

- b. The amount of clinic abuse by non-indigents receiving free professional service from physicians.

4. That the governing boards of hospitals in New Jersey be acquainted with certain problems common to the administrative staffs, professional staffs, and governing boards; and that these governing boards be asked to consider the problems submitted to them, thus assisting in the solution of these problems. These problems are to be limited to the problems which should be particularly considered by governing boards. Among these problems might be:

- a. The question of auxiliary service fees, such as those charged for laboratory and x-ray work.

- b. The possible readjustment of private room and ward rates; and a study of the actual cost per day per patient for ward and private room care.

- c. Consideration of the possibility of increasing accommodations for private patients of moderate circumstances as ward patients, at a moderate cost for hospitalization, and reduced fees to the attending physicians.

- d. That each member of the governing board consider the efficiency of the socio-economic investigation in his hospital; and take steps to assure proper socio-economic investigation of each patient attending the clinics, or admitted to the hospital for care.

- e. That governing boards consider the per diem rates charged Workmen's Compensation cases to assure that sufficient charge for hospital care is made to cover cost of that hospital care; and that this cost be up to \$5.00 a day per patient if this amount is necessary to defray the actual cost.

- f. That the governing boards consider the possibility of permitting attending physicians to make charges for their service in the care of all compensation cases admitted to the hospitals.

- g. That the governing boards consider the problem of accident cases admitted to the hospitals, to assure that each case has a proper socio-economic investigation to determine the economic status of the patient and his ability to pay for private care.

- h. That the governing boards of hospitals give instructions that all bills submitted to patients by the hospital for hospital care state on the bill that the amount is for hospital service only, and not for the payment of professional services rendered by physicians; and that instances where there are exceptions to this, the exception be so stated.

The above list of problems relative to governing boards is at present only tentative, and will be given further consideration at subsequent meetings.

The next meeting of the committee will be held on Sunday, November 12th, 1939, at 11:00 a. m., at the Executive Offices, Trenton.

NORMAN M. SCOTT, M.D.,
Executive Assistant.

C. SUB-COMMITTEE ON PUBLIC RELATIONS

JOSEPH H. KLER, M.D., New Brunswick, N. J., Chairman

A meeting of the Sub-Committee on Public Relations with representatives of county medical Societies was held in Room 417 of the Broad Street National Bank Building, Trenton, N. J., Sunday, September 24, 1939, beginning at 2:30 p. m., with the Chairman, Dr. J. H. Kler, presiding. Twenty-four persons were present, including Dr. E. Zeh Hawkes, President of The Medical Society of New Jersey; and Dr. Watson B. Morris, President-Elect.

Others present were:

ATLANTIC COUNTY—

Edward F. Uzzell, M.D., Atlantic City, President

BERGEN—

George M. Knowles, M.D., Hackensack, President
R. C. Schretzmann, M.D., member Bergen County Society Public Relations Committee

CAMDEN—

A. J. Casselman, M.D., Camden, Chairman Public Relations Committee

CAPE MAY—

George F. Dandois, M.D., Wildwood, Chairman Public Relations Committee
Clarence Way, M.D., Sea Isle City, Secretary

ESSEX—

Francis C. Weber, M.D., Newark, Chairman Essex County Society Public Relations Committee
Edgar P. Cardwell, M.D., Newark, member of State Society Public Relations Committee, and of Essex County Society Public Relations Committee

GLOUCESTER—

Louis K. Collins, M.D., Glassboro, County Society Public Relations Committee
Chester I. Ulmer, M.D., Gibbstown, Secretary

HUNTERDON—

Joseph J. Cartisser, M.D., Sergeantsville, President

MERCER—

A. Dunbar Hutchinson, M.D., Trenton, Secretary

MIDDLESEX—

Joseph H. Kler, M.D., New Brunswick, Chairman State Society Committee on Public Relations

OCEAN—

E. G. Herbener, M.D., Lakewood, Chairman Public Relations Committee
W. E. Dodd, M.D., Beach Haven, Vice-President

SOMERSET—

A. W. Pigott, M.D., Skillman, President

SUSSEX—

E. K. Hawke, M.D., Sussex County Society Public Relations Committee

UNION—

Foster Orton, M.D., Rahway

WARREN—

W. R. Bostwick, M.D., Blairstown, President

Also present were LeRoy A. Wilkes, M.D., Executive Officer; Norman N. Scott, M.D., Executive Assistant; and Donald Benson, assistant to Public Relations Committee.

ADDRESS BY PRESIDENT HAWKES

The Chairman called upon President Hawkes, who urged that no committee make any pronouncement until it had the support of its whole membership.

PUBLIC RELATIONS PROGRAM FOR COUNTY SOCIETIES

Chairman Kler presented the following Public Relations program for County Societies:

1. Creation of a Public Relations Committee in every County Medical Society which does not now have this committee.
2. Creation of a committee of physicians in each community in which there is a public library, to advise with the librarian concerning medical literature presented to lay readers.
3. Creation of a committee to examine each new issue of the telephone directory to see that physicians are properly classified, and to prevent any others than bona fide physicians from being classified as physicians. In the event of suspected irregularities the committee can make a complaint to the State Board of Medical Examiners.
4. Distribution of the weekly health feature, "The M.D. Says:", to the press by County Medical Societies.
5. Development of county radio programs. Some of the County Medical Societies are now conducting excellent radio programs. There are fourteen radio stations in New Jersey, located in ten counties. Thus, not all county societies have access to a station within the county. The State could be divided into districts such that each county which has a radio station would invite a neighboring county society without a station to participate in a radio program. A suggested division of districts is attached (page 678).
6. Talks to lay groups. The county society public relations committee should contact organizations within the county, and advise them that it is prepared to provide speakers on medical topics. A suggested form letter for this purpose has been prepared by the committee.

7. Promotion of a paid institutional advertising program in newspapers on a county-wide basis.

8. Health Weeks. It is suggested that each County Medical Society sponsor an annual Health Week. This would provide an opportunity for intensive publicity of each County Medical Society.

PAID INSTITUTIONAL ADVERTISING

In the discussion of item seven of the Public Relations Program, Dr. Cardwell presented a résumé of his efforts to determine a basis for the need of a State-wide advertising campaign in answer to questions of medical economics, which have arisen in the minds of the people.

President-Elect Morris endorsed the idea of a paid advertising program to present organized medicine's position in medical economics.

PRESS PUBLICITY

In the discussion of item four of the Public Relations program, Dr. Ulmer said his experience in Gloucester County indicated that the most effective contact with the press was through the personal approach of a physician well known to the editor.

TALKS TO LAY GROUPS

Under item six of the Public Relations Program, Chairman Kler announced that loan material for address is available from the Public Relations Committee, as follows:

1. Speakers' Service Bulletins. Nineteen prepared talks with press releases attached.
 2. Hygeia Collection. Sixty packages of material culled from Hygeia magazine.
 3. Radio Talks. About 500 prepared talks which have been delivered by physicians.
 4. Scientific Material. Classified articles from copies of The Journal of The American Medical Association.
 5. A file on medical economics.
- Indices of any or all this material may be obtained from the Committee on Public Relations.

Dr. Weber, of Essex, cited the effectiveness

of talks to lay groups. He said Essex physicians had delivered 200 talks during the last year.

Dr. Wilkes stressed the importance of every physician participating in the public relations program. He said the public relations committees can point the way, but that every physician must participate to make the work effective. He urged physicians to acquaint themselves with the subject of medical economics and to familiarize themselves with the proposed Medical Service Plan.

President Hawkes urged that the aid of the Woman's Auxiliary be enlisted in contacting lay groups for speaking engagements.

RADIO TALKS

Under item five of the Public Relations Program, Chairman Kler announced that radio districts and stations for broadcasting are available to the several counties, as follows:

District	Counties	Station and Location
1.	Atlantic Cape May	WPG—Atlantic City
2.	Bergen	WPSK—Hackensack
3.	Camden Gloucester	WCAM—Camden
4.	Cumberland Salem	WSNJ—Bridgeton
5.	Essex Morris Union	WOR—Newark WHIB—Newark WNEW—Newark
6.	Hudson	WAAT—Jersey City WHOM—Jersey City WLWL—Kearny
7.	Hunterdon Mercer Burlington	WTNJ—Trenton
8.	Warren Somerset Middlesex	WAWZ—Zarephath
9.	Monmouth Ocean	WCAP—Asbury Park WBRB—Red Bank
10.	Passaic Sussex	WNEW—Paterson

D. SUB-COMMITTEE ON LEGISLATION

B. S. POLLAK, M.D., Jersey City, N. J., Chairman

A meeting of the Sub-Committee on Legislation was held on Sunday, October first, 1939, at 11 a. m. in the Executive Offices. Those present were: Dr. B. S. Pollak, Chairman, presiding; Drs. Wendell J. Burkett, H. Roy Van Ness, Frederic J. Quigley, Robert E. Watkins, and Joseph M. Kuder; and Samuel Alexander, Consultant.

Dr. Pollak spoke briefly on the activities of last year and thanked Dr. Alexander and Dr. Quigley for their efforts in getting A-210 and several other bills passed in the Legislature.

He said that during the year there has been a misunderstanding of the motives of physicians. During the coming year we should adopt a policy that no bills in the Legislature

be endorsed unless they are thoroughly understood by ourselves and accepted by the medical profession.

No legislative bills will be introduced this year by The Medical Society of New Jersey unless something of great importance develops. The Workmen's Compensation Bill will be introduced by the State Department of Labor, and we will then express the views of the medical profession.

SPECIAL LEGISLATION

Early in 1939 there were two special bills introduced in the Legislature, one by Assemblyman Wegrocki from Essex County, and one by Assemblyman Artaserse from Hudson County, the purpose of which will admit certain individuals for examination by the State Board of Medical Examiners. Both of these bills passed the Assembly and the Senate and were filed by pocket veto. Two similar bills were recently introduced by the same Assemblymen for the benefit of the same individuals.

The State Board of Medical Examiners passed a resolution in July regarding the Wegrocki Bill in relation to Dr. Ford—A-668,—and Dr. Wegrocki had knowledge of said resolution and mentioned this fact either in the Republican caucus or in the House. Probably because of his statement the legislators were influenced; but as a matter of fact, this resolution had never been forwarded to the Governor nor to the legislature. The Legislative Committee felt it was important for the State Board of Medical Examiners not to take action on bills until its members had ascertained the Society's actions.

Dr. Burkett moved the committee adopt the following resolution and present it to the Welfare Committee for its adoption. Seconded by Dr. Quigley. Unanimously adopted:

Whereas, certain bills have been introduced in both houses of the Legislature at various times with the purpose of approving certain individual physicians for licensure, and

Whereas, such legislation is contrary to the Medical Practice Act in respect to requirements for licensure in this State,

Therefore be it resolved, that The Medical Society of New Jersey inform the Governor of the State, respective legislators, and the State Board of Medical Examiners that we are vigorously opposed to legislation which would permit any individual to

take an examination, having qualifications below the requirements of the Medical Practice Act.

APPROACH TO LEGISLATORS ON THE SOCIETY'S ATTITUDE

The question was raised as to the best method of informing the legislators of the Medical Society's attitude toward public health measures.

Dr. Quigley moved that a letter be sent to all candidates for the legislature prior to the election (similar to the letter drafted a few years ago), calling attention to the fact that the medical men have an interest and knowledge of public health matters, and request them, before taking any action affecting public health and the standards of licensure, to afford the representatives of the county medical societies to express their points of view. Seconded by Dr. Kuder, unanimously carried. (This letter is to be sent from the Executive Offices.)

LEGISLATIVE AGENT

The Chairman reported last year it was decided to have someone here in Trenton to represent the Society throughout the year, someone familiar with legislation.

Dr. Pollak felt the committee should go on record as favoring a legislative representative, preferably a medical man on part-time basis, in order to protect the Society's interests,—someone who is thoroughly acquainted with medical problems and knows the ins and outs of legislation.

Dr. Burkett moved the committee approve the appointment of a legislative agent, preferably a medical man. Seconded and carried.

Dr. Quigley recommended that a list of the legislators and how they vote on bills of especial interest to the medical profession, with a star for candidates for reelection, be published in The Journal to inform the membership how the legislators stand on legislation of interest to the Society.

(Is printed in the October, 1939, Journal; page 620.)

Dr. Watkins thought it would be a good idea to call a meeting of the keymen in Trenton when important bills are on the floor of the Legislature. Dr. Alexander stated this is not necessary since the Executive Offices contact all keymen by phone when important bills are coming to a vote.

Meeting adjourned 1:00 p. m.

TRUSTEES' MEETING OF OCTOBER FIFTEENTH

A meeting of the Board of Trustees of The Medical Society of New Jersey was held in the Executive Offices, Trenton, at 11:30 a. m., October 15th, 1939, with Chairman Hollinshed presiding, and the following additional members present: Drs. Crowe, Secretary; Young, North, Marsh, Costello, McBride, Eagleton, Stahl, Alexander, Hawkes, Hornberger, Morris, Lee, and Lewis.

Those present on invitation of the Board were Drs. Wilkes, Overton, Scott, Pollak, Barkhorn, and Cosgrove.

Dr. Norton was excused for absence on account of illness.

The resignation of Dr. H. W. Nafey from the Board on account of ill health was accepted; and the Secretary was instructed to write a letter to Dr. Nafey expressing the appreciation of the Board for his years of faithful service.

Dr. Nafey was elected Trustee on June 4, 1931, to succeed Dr. Martin S. Meinzer, resigned. He was chosen Secretary to succeed Dr. James Hunter, Jr., who had died on June 1, 1931; and held the office until June, 1939, when Dr. Crowe was elected Secretary.

President Hawkes was instructed to write to the Presidents and Secretaries of four counties of the Third Councilor District (Middlesex, Mercer, Somerset and Hunterdon) requesting them to confer and nominate a successor to Dr. Nafey.

A request was received from Dr. Olin West, Secretary of the American Medical Association, that the Trustees send a representative of the State Society to Chicago on November 17 and 18, to present the Medical Service Plan of New Jersey to the Annual Conference of State Secretaries and Editors. Secretary Stahl and Editor Overton will also attend the Conference at the expense of the A. M. A. as the official representatives of The Medical Society of New Jersey.

The Trustees granted the request of Dr. MacMillan, Chairman of the Special Committee for the Study of Eugenic Sterilization, that it be authorized to send out 250 mimeo-

graphed copies of the committee's annual report, since it had been printed in the Transactions in abstract.

The Board approved the suggestion of President Hawkes that a Conference of County Society Officers be held later in the Fall.

The Board discussed the advisability of appointing a physician as Legislative Agent of the Committee on Legislation. The duties of the agent would be to address County Medical Societies and Auxiliaries on matters of Medical Legislation; to arrange conferences of key men and County Society representatives with legislators; and in general, to act as the field agent of the Legislative Committee.

The project was approved by the Board.

Dr. Samuel A. Cosgrove, Chairman of the Second Fall Clinical Conference, reported on the plans for the Conference, to be held under the auspices of the Hudson County Medical Society on November 9th and 10th in Jersey City. The plans were approved.

Dr. Norman M. Scott, Executive Assistant, exhibited a voluminous report on the Survey of Medical Services in New Jersey that had been compiled last Spring on blanks issued by the American Medical Association. This survey had been highly commended by officials of the A. M. A. (Journal, May, 1939, page 344.)

A committee was appointed to review the Survey with the object of approving it formally.

Two bound volumes of the minutes of the Board of Trustees were shown. These covered the meetings from November 9, 1933, up to the end of 1938. It was suggested that a search be made for the minutes of the preceding years; and that those for 1939 be indexed and bound in permanent form.

An index of the Transactions of the first fifty years of the Society was also shown. It was suggested that the compilation of the index be brought up to date, and that a copy be deposited in a central library, such as that of the Academy of Medicine in Newark, where it might be consulted by historians and research workers.

SHONGHUM MOUNTAIN SANATORIUM

Early in October the Shonghum Mountain Sanatorium, the tuberculosis sanatorium of Morris County, began construction of a new building, which will house seventy-five patients. In the basement there will be an auditorium and stage, dining rooms, kitchen, laundry, and boiler plant. The first and second

floors will be given over entirely to the housing of patients.

The central portion of the building will have a third floor. Here will be located operating rooms, and the other accommodations incident to this service.

This new building will be connected with

the present hospital building by a glazed arcade having three floor levels.

The present hospital building, which is not fireproof, will no longer be used for housing patients. It will be remodeled, and given over to administrative uses. Here will be located the administrative offices, laboratory, x-ray

suite, library, dental department, and other services.

The new building will be completed in a year, and the remodeling of the present hospital building will take an additional four months, according to the schedule of the architect, Campbell Voorhees, of Morristown.

AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

WALTER B. MOUNT, M.D.

At the first American Congress on Obstetrics and Gynecology at Cleveland, Ohio, on September 11-15, 1939, the following eight representatives from New Jersey were on the program:

Dr. Arthur W. Bingham, East Orange, Chairman, Committee on Maternal Welfare, Medical Society of New Jersey, and Chief Advisory Obstetrician, Bureau of Maternal and Child Health, State Department of Health.

1. "External Education on Maternal and Neonatal Care." Paper read before the Joint Session on September 14.
2. "Maternal Mortality Statistics for New Jersey." Exhibit of Charts in Educational and Scientific Exhibit.
3. Member of Membership Committee.

Dr. Samuel A. Cosgrove, Jersey City, Clinical Professor of Obstetrics, College of Physicians and Surgeons, Columbia University; Medical Director, Margaret Hague Maternity Hospital.

"Reduction of Unwarranted Operative Incidence in Obstetrics." Paper read before the Medical Section on September 12.

Langdon Gill, R.N., Haddonfield.

"Standards of Nursing Service for Postpartum Care." Paper read before the Joint Session of Hospital Administrators and Educators with the Nursing Section, September 15.

Mr. F. Stanley Howe, Orange, Administrator, Orange Memorial Hospital.

"Socio-economic Aspects of Institutional Maternity Care." Paper read before the Joint Session, September 13.

Clara Konrad, R.N., Jersey City, Assistant Superintendent and Director of Nursing Service, Margaret Hague Maternity Hospital.

"Standards of Nursing Service in the Delivery Suite." Paper read before the Joint Session, Hospital Administrators and Educators with the Nursing Section, September 15.

Dr. Walter B. Mount, Montclair.

"Obstetrical Phantoms." Exhibit of photographs in Educational and Scientific Exhibit.

Dr. George O'Hanlon, Jersey City, Medical Director, Department of Public Affairs, Medical Center.

"Coöperative Agreement Between Private Hospitals and Local Public Health Service of the Municipality or the County." Paper read before the Hospital Administrators and Educators Section, September 13.

Dr. LeRoy A. Wilkes, Trenton, Executive Officer, Medical Society of New Jersey.

"General Summary of the Findings of the Congress. Public Health." Paper read before the Joint Session, September 15.

PROGRESS IN THE CAMPAIGN AGAINST VENEREAL DISEASES

SYPHILIS

The following summary of the results of the campaign against venereal diseases throughout the United States was given to the press on October 16, 1939, by Dr. R. A. Vonderlehr, Assistant Surgeon-General in charge of the Division of Venereal Diseases of the U. S. Public Health Service:

In 1930, 1,632,083 blood tests were reported; while the exact count for the fiscal year closing last June 30 stood at 5,588,285.

The number of clinics treating patients for syphilis during the fiscal year 1939 totaled 2,405, an increase of 287 per cent over 1930.

During the fiscal year 1939, 659 more clinics reported to the Public Health Service than during 1938.

The number of doses of the arsenical drugs used for treatment of syphilis has risen to \$10,656,253, or 84 per cent greater than the total used in 1933.

GNORRHOEA

There have also been substantial increases in the number of laboratory tests for gonorrhea. In the fiscal year 1939, 605,631 tests were reported. This constitutes an increase of 73 per cent over 1930.

ESSENTIALS OF A LOCAL CAMPAIGN

Dr. Vonderlehr recommended that every town and city check its program against the nine elements considered by the U. S. Public

Health Service to be essential to adequate control of syphilis. These are:

1. A trained public health staff which knows how to deal with syphilis.
2. Regulations requiring reporting and follow-up on all cases of syphilis.
3. Facilities for treatment of all patients—both those who can and who cannot pay.
4. Free laboratory service available to all physicians and clinics.
5. Distribution of free antisyphilitic drugs to all physicians and clinics.
6. Blood tests for all pregnant women, and treatment where required.
7. Blood tests of all persons before marriage.
8. Blood tests in all complete physical examinations.
9. An educational program.

NUMBER OF CHILDREN REPORTED AS RECEIVING FREE STATE BIOLOGICALS FROM JULY 1, 1939, TO SEPTEMBER 30, 1939

DIPHTHERIA TOXOID

County	Total to Aug. 31	Month of Sept.	Total to Sept. 30	Average per Month
Atlantic	36	31	67	22.3
Bergen	419	151	570	190.
Burlington	19	2	21	7.
Camden	647	49	696	232.
Cape May	28	1	29	9.6
Cumberland	9	3	12	4.
Essex	1738	936	2674	891.3
Gloucester	41	5	46	15.3
Hudson	1331	928	2259	753.
Hunterdon	0	0	0	0
Mercer	449	79	528	176.
Middlesex	37	34	71	23.6
Monmouth	767	19	786	262.
Morris	183	23	206	68.6
Ocean	0	0	0	0
Passaic	723	278	1001	333.6
Salem	15	28	43	14.3
Somerset	28	15	43	14.3
Sussex	0	0	0	0
Union	339	145	484	161.3
Warren	4	3	7	2.3
Totals	6813	2730	9543	3181.

SMALLPOX VACCINE

County	Total to Aug. 31	Month of Sept.	Total to Sept. 30	Average per Month
Atlantic	20	61	81	27.
Bergen	768	332	1100	366.6
Burlington	103	60	163	54.3
Camden	226	418	644	214.6
Cape May	32	10	42	14.
Cumberland	42	37	79	26.3
Essex	918	819	1737	579.
Gloucester	67	66	133	44.3
Hudson	1546	1042	2588	862.6
Hunterdon	9	6	15	5.
Mercer	267	286	553	184.3
Middlesex	107	128	235	78.3
Monmouth	109	55	164	54.6
Morris	232	154	386	128.6
Ocean	18	0	18	6.
Passaic	530	409	939	313.
Salem	54	63	117	39.
Somerset	184	164	348	116.
Sussex	0	0	0	0
Union	374	305	679	226.3
Warren	47	51	98	32.6
Totals	5653	4466	10119	3373.

OBITUARIES

DR. EUGENE Z. HILLEGASS

Dr. Eugene Z. Hillegass, aged eighty-five years, passed away almost without warning in his home at Mantua during the early morning hours of October 8th, 1939. He was born in Pennsburg, near Philadelphia, on January 15th, 1854. He graduated from the Philadelphia College of Pharmacy in 1874 and conducted a drug store for several years. He graduated from the Jefferson Medical College in 1880. He practiced for five years in Philadelphia, and for fifty-four years in Mantua, and was in active practice up to the day of his death.

Dr. Hillegass was a typical rural practitioner of medicine, well liked by his patients and his medical colleagues. He and his close friend, Dr. Henry B. Diverty, were given a testimonial dinner by the

Gloucester County Medical Society on April 15, 1937, for practicing medicine during over half a century. An excellent portrait of the two, taken during the meeting, is printed on page 355 of the May, 1937, number of this Journal.

DR. T. L. CALDRONEY

Dr. Thomas Leo Caldrony died on August 2nd, 1939, in his home in Ridgefield Park, aged forty-seven years.

Dr. Caldrony was a native of Bergen County. He graduated in medicine from New York University in 1917, and ever since that time he has practiced in Ridgefield. He was Secretary of the Bergen County Medical Society in 1926, and was active in the Rotary and Masonic circles.

DECEASED PHYSICIANS—NEW JERSEY

Data Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Earnest Casini	68	Sept. 10, 1939	Garfield		Cerebral hemorrhage.
Charles R. Hutcheson	43	Sept. 22, 1939	Colwick, Camden Co.	Same	Suicide.
James E. Kelly	38	Sept. 3, 1939	Jersey City	Same	Coronary thrombosis.

BOOKS RECEIVED FOR REVIEW

Diseases of the Skin. By R. L. Sutton and R. L. Sutton, Jr. 10th ed. Pp. 1549. Price \$15.00. St. Louis, C. V. Mosby & Company. 1939. This book was reviewed in the October issue of the Journal, but through an oversight the publisher's name was not given.

Eye, Ear, Nose and Throat Manual for Nurses. By Roy H. Parkinson. 4th ed. Pp. 243. Price \$2.25. St. Louis, C. V. Mosby Company. 1939.

Principles of Chemistry. By Joseph H. Roe. Pp. 503. Price \$3.00. St. Louis, C. V. Mosby Company. 1939.

Microbiology and Pathology. By Charles F. Carter. Pp. 755. Price \$3.25. St. Louis, C. V. Mosby Company. 1939.

Operative Orthopedics. By Willis C. Campbell. Pp. 1154. Price \$12.50. St. Louis, C. V. Mosby Company. 1939.

Functional Disorders of the Foot. By Frank D. Dickson and Rex L. Diveley. Pp. 305. Price \$5.00. Philadelphia, J. B. Lippincott Co. 1939.

Primer of Allergy. By Warren T. Vaughan. Pp. 140. Price \$1.50. St. Louis, C. V. Mosby Company. 1939.

Clinical and Experimental Use of Sulphanilamide, Sulfapyridine and Allied Compounds. By Perrin H. Long and Eleanor A. Bliss. Pp. 319. Price \$3.50. N. Y., Macmillan. 1939.

Textbook of Occupational Diseases of the Skin. By Louis Schwartz and Louis Tulipan. Pp. 799. Price \$10.00. Philadelphia, Lea & Febiger. 1939.

Synopsis of Pediatrics. By John Zahorsky, assisted by T. S. Zahorsky. 3rd ed. Pp. 430. Price \$4.00. St. Louis, C. V. Mosby Co. 1939.

Psychobiology and Psychiatry; a textbook of normal and abnormal human behavior. By Wendell Muncie with a foreword by Adolf Meyer. Pp. 739. Price \$3.00. St. Louis, C. V. Mosby Co. 1939.

Textbook of Nervous Diseases. By Robert Bing. Trans. and enlarged by Webb Haymaker from the 5th German ed. Pp. 838. Price \$10.00. St. Louis, C. V. Mosby Co. 1939.

BOOK REVIEWS

MICROBIOLOGY AND PATHOLOGY. By Carter. 2nd edition. Pp. 755. Price \$3.25. St. Louis, C. V. Mosby Company. 1939.

This book, designed for the instruction of nurses in microbiology and pathology, presents a wide scope of material clearly. Of necessity, the text is simplified and in many places sketchy. The portion devoted to microbiology is well coördinated, and gives a well-rounded discussion of the subject including descriptions and illustrations of laboratory equipment and technic. At the end of each chapter there is a section devoted to laboratory exercises and questions for review. Microbiology is discussed under four major headings: General Principles, Relation of Bacteria to Disease, Bacteriology of Water and Milk, and Special Bacteriology. The portion devoted to general principles is excellent and is a good foundation for the more comprehensive text that follows.

The section devoted to pathology covers almost the whole field of pathology including surgical pathology. In consequence, it devotes a little space to a great number of topics and does not give a co-ordinated picture for an elementary student. It would have been better to sacrifice quantity for a more detailed discussion of elementary processes,

both pathological and physiological, with an attempt to correlate these to nursing care and technic. There is no inclusion of questions at the ends of the chapters on pathology.

The illustrations, as a whole, are good. The inclusion of a glossary at the end of the book is an excellent and important idea.

W. LIPSTEIN, M.D.

OPERATIVE ORTHOPEDICS. By Willis C. Campbell. Pp. 1154. Price \$12.50. St. Louis, C. V. Mosby. 1939.

Dr. Campbell's book should be in the library of every orthopedic surgeon. It is complete and thorough in its subject matter; the illustrations are clear and they convey the author's ideas concisely and accurately. The numerous references are a great help to the busy surgeon who cannot find the time to do extensive searching in the literature for material on the subject in which he is interested.

The chapter on Surgical Approaches is exceptionally well done and fills a long-felt need of the surgeon. The chapter on physiology and pathology is comprehensive and enlightening, especially the discussion on calcium metabolism.

A TEXT-BOOK OF OCCUPATIONAL DISEASES OF THE SKIN. By Louis Schwartz, M.D., Medical Director, United States Public Health Service, in charge of Dermatoses Investigations, Washington, D. C., and Louis Tulipan, M.D., Clinical Professor of Dermatology and Syphilology, New York University, College of Medicine, New York City. Pp. 799. Price \$10.00. Philadelphia, Lea & Febiger. 1939.

With widespread industrialization and extensive employment of synthetic compounds, there has been an universal increase of skin affections primarily due to the different external irritants. The authors of this book have covered the conditions that may develop in the course of handling or inhaling substances that are encountered in industry. The authors do not confine themselves to the purely clinical descriptions, but give a detailed description of the different processes in manufacturing, and the composition of the offending agent.

Special chapters are devoted to parasitic and infectious skin affections. While they are usually found in texts on dermatology, their inclusion here serves a useful purpose, as time and again these conditions are seen in association with some form of employment, or develop on top of an occupational dermatitis.

The black and white photographs are clear and carefully selected to give a clear idea of the descriptive text. There is also an extensive bibliography appended to most chapters.

This book is indispensable to the dermatologist. It should also be found of great value to the plant physician, and the plant engineer, as well as to those who have to deal with medico-legal problems.

N. B. HELLER, M.D.

EYE, EAR, NOSE AND THROAT MANUAL FOR NURSES.

By Roy H. Parkinson. 4th ed. Pp. 243. Price \$2.25. St. Louis, C. V. Mosby Company. 1939.

The fact that this little book has reached a fourth edition since 1925 recommends it for nursing instruction. It is notable for omissions of debatable matter, detailed anatomical considerations and diagnosis and treatment with which so many nursing school courses are burdened. Seventy-nine illustrations help to give simple and vital nursing instructions.

FEVER AND PSYCHOSES, by Gladys C. Terry. Paul B. Hoeber, Inc. Medical Book Department of Harper & Brothers. New York. 1939. 167 pp.

This volume, dedicated to the memory of Dr. Frederick Tilney, is an excellent presentation of the literature and current opinion on the effects of fever on certain psychoses and epilepsy.

It will prove invaluable as a reference work to those who are interested in the study and application of artificially induced high temperatures in the treatment of the various morbid conditions met with in general medical, as well as in functional neurological disorders. It gives bibliographic assistance for research into a subject upon which there is very little real scientific knowledge, as judged from the numerous opinions and hypotheses quoted in

the book. Where there is smoke there must be some fire.

As the foreword by Dr. Dudley Roberts sets forth, it is to be hoped that this contribution will afford a stimulus for further study of this subject, upon which there is still lacking "the sort of proof which would come about through a well-rounded clinical investigation, with careful selection of pre-determined groups of cases, the elimination of all possible factors other than fever as a therapeutic agent, and the most painstaking evaluation by follow-up study."

CHRISTOPHER C. BELING, M.D.

OTOLARYNGOLOGY IN GENERAL PRACTICE. By Lyman Richards, M.D. Cloth. Pp. 331, with illustrations. New York: the MacMillan Company, 1939.

Dr. Richards is following the precedent established by his father, Dr. George Lyman Richards, who wrote a book on the nose and throat for the general practitioner thirty-five years previously. The present author is otolaryngological surgeon to the Peter Bent Brigham Hospital in Boston, and on the teaching staff of Harvard Medical School. He is to be congratulated upon his success in presenting to the general medical man the subject of ear, nose and throat in easily readable and understandable form.

Dr. Richards has not made the mistake of devoting too much attention to rare and unusual conditions. He stresses the high incidence of upper respiratory tract diseases in the practice of the general doctor, and discusses their *clinical aspects*, while omitting much anatomical, physiological and pathological information that fills the pages of the usual otolaryngological textbooks. The technic of the common operative procedures, such as myringotomy, tonsillectomy, and incision for peritonsillar abscess, is given with great clarity, while the details of mastoidectomy and bronchoscopy—problems for the specialist—are omitted. The *indications* for the latter procedures are well presented, however.

The factual data are modern and up-to-date, as shown, for example, in the clear discussions of the use of sulfanilamide in acute otitic infections and the condition of nasal allergy.

This authoritative yet simple, clear and readable book will be found very useful to the medical student, the interne, and most of all to the general practitioner—the man on the firing line, for whom it is especially written.

WILLIAM B. NEVIUS, M.D.

LIFE AND LETTERS OF FIELDING H. GARRISON. Solomon R. Kagan, M.D. With an introduction by Prof. James J. Walsh. 287 pp. Boston, Medico-Historical Press. 1938.

If for no other reason, Dr. Kagan has rendered a service in presenting the unusually fine letters of Fielding Garrison to the public.

The remainder of the book would appear to be more of a preface to the letters, and suffers perhaps from incomplete digestion of material. One also cannot help but feel that a man as outstanding as Garrison deserves a more complete biography.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

NOVEMBER, 1939

7 Camden	9 Somerset
7 Hudson	10 Atlantic
8 Mercer	10 Salem
8 Ocean	14 Bergen
8 Union	15 Middlesex
9 Burlington	16 Gloucester
9 Essex	16 Morris
9 Passaic	22 Monmouth

DECEMBER, 1939

5 Camden	14 Burlington
5 Hudson	14 Essex
8 Atlantic	14 Passaic
8 Salem	14 Somerset
12 Bergen	20 Middlesex
12 Cumberland	21 Gloucester
13 Mercer	21 Morris
13 Ocean	27 Monmouth

CAPE MAY COUNTY

Clarence W. Way, M.D., Reporter

A meeting of the *Cape May County Medical Society* was held at the Hotel Bellevue, Cape May Court House, N. J., at 9 p. m., October 3, 1939, with President Aldrich C. Crowe presiding. The members present were:

A. C. Crowe	Samuel S. Giddings
Millard C. Cryder	George Brooks
H. H. Hornstein	George F. Dandois
Herschel Pettit	Jules Cooper
C. W. Way	

Guest speaker, Dr. Edward Burt, Philadelphia.

Guests from The Medical Society of New Jersey:

Dr. Elias J. Marsh, Paterson, Second Vice-President, and

Dr. Norman M. Scott, Executive Assistant

Regrets were received from:

Dr. LeRoy A. Wilkes, Executive Officer, and

Dr. Frank Overton, Editor.

MEETING DATES

Dr. Crowe announced that the Society will hold monthly meetings except during July, August, and September.

The date of the annual meeting was changed to May in order to conform to the other county medical societies in the State.

COMMITTEE APPOINTMENTS

The personnel of the new committees for the coming year were read, and will be published in the Bulletin of the Society.

CANCER CONTROL

President Crowe reported that the Woman's Auxiliary will be active in education during the coming year, and will hold three meetings for lay groups on the subject "Cancer Control".

PUBLIC RELATIONS

Dr. George F. Dandois, Wildwood, gave a report of the Public Relations Committee.

Dr. Norman M. Scott, Trenton, spoke on the importance of the objective that every case of sickness in Cape May County should receive adequate medical care.

Dr. Elias J. Marsh addressed the Society, and

brought a message from Dr. E. Zeh Hawkes, President of The Medical Society of New Jersey.

SCIENTIFIC

Dr. Edward Burt of the Pediatric Staff, Jefferson Medical College, gave a most interesting and instructive address on "Intracranial Hemorrhages in the New-born".

CUMBERLAND COUNTY

F. Muriel Ramsey, M.D., Reporter

A meeting of the *Cumberland County Medical Society* was held in the Cumberland County Hospital for the Insane, with the President, Dr. J. Franklin Reeves, of Bridgeton, N. J., presiding.

It was suggested by the President that a permanent gift be sent to Dr. E. S. Corson, who is confined to his home with illness. Dr. Corson has been very active in the society for many years. He spent his early life in mission work in foreign fields.

It was decided that there would be monthly meetings in the various hospitals within the county on alternate months.

PUBLIC RELATIONS COMMITTEE

A Public Relations Committee was appointed by the President, whose duty it will be to list those names of various physicians within the county who are interested in public speaking relative to medical work. The committee is composed of Dr. F. Muriel Ramsey, Dr. Edward Thalheimer, and Dr. Benjamin Berkowitz.

BABY KEEP-WELL CLINIC

The Baby Keep-Well Clinic in Millville, N. J., will be covered by the following four physicians: Drs. Miller, Ramsey, Bennett and Brannin conducting rotating services.

SCIENTIFIC PROGRAM

Dr. John Loper, resident physician of the hospital, gave an interesting presentation of patients in the institution. Four cases were used for study showing the similarity of congenital syphilis and dementia praecox. Dr. Loper brought out the point that in most of the institution cases dementia praecox was found to exist in patients who had shown

a high grade of intelligence before its onset, while those of syphilitic condition were usually dull, as shown by their early scholastic records.

He pointed out that a great number of the institution cases were of the senile group. He felt that many of these cases could be treated within the home if adequate nursing care could be given. This explains most of the mortalities in the institution.

Great progress was noted during a tour of the institution in its equipment. The hospital unit used for treatment was especially well equipped with its x-ray department and treatment rooms. The doctors commented on the sanitation of the institution.

It was the feeling of the physicians present that meetings should be held more frequently in the county institutions so that a knowledge of their work could be better understood.

ESSEX COUNTY

Paul S. Hosp, M.D., Reporter

The *Essex County Medical Society* held its regular monthly meeting at the Academy of Medicine, Thursday, October 12th, 1939. Dr. Royal Schaaf, President, called the meeting to order promptly at nine p. m.

This was the biggest and best attended meeting so far. Over 500 crowded into the auditorium.

OFFICIAL VISITOR

Dr. Watson B. Morris, President-Elect of The Medical Society of New Jersey, was introduced by Dr. Schaaf. Dr. Morris mentioned briefly some of the activities that were taking place in the State Society. He told about the Ways and Means Committee, and that it formed an important link between the committees and the President. He said the Voluntary Health Insurance Plan should have our whole-hearted support. He mentioned about the extensive study being made in the proposed change of the Compensation Laws.

As to National Health Program,—twenty-one states have taken it under consideration and will report at the next A. M. A. meeting. New Jersey is one of them.

SCIENTIFIC

Dr. Harrison Martland, Chief Medical Examiner of Essex County and Professor of Forensic Medicine, New York University College of Medicine, gave an illustrated lecture, "Doctor Watson and Mr. Sherlock Holmes". This dealt with the various forms of violent death and their detection. Special emphasis was laid upon the surgical lessons obtained from the investigation of such cases.

As the second part of his lecture the doctor took for his topic "Sudden Death from Natural Causes". This was beautifully demonstrated by opaque projections of actual specimens.

BREAST MILK STATION

At the meeting above Dr. Chester R. Brown, Chairman of the Child Welfare Committee of Essex County, reported that in accordance with the program of last year's report, the Breast Milk Station

at the Babies' Hospital-Coit Memorial had been successfully launched. Any doctor in the State can get for immediate delivery mother's milk in the frozen state, or if ordered ahead can be procured in liquid form. The milk costs thirty-five cents per ounce in either form. Indigent cases will also be taken care of, if worthy. This new service stands out prominently, and the committee is to be commended on its noble work.

POST-GRADUATE AFFILIATION

The Committee on Post-Graduate Instruction has secured affiliation with New York University College of Medicine for graduate instruction of members of the Essex County Medical Society. Still to be formulated is a plan for the utilization of this affiliation. The committee is studying ways and means to develop this work in the Newark City Hospital.

Attention is called to the year's programs of meetings of the society:

November 9th—Address by Dr. Morris Fishbein, Editor of the Journal of the American Medical Association.

December 14th—Address by Dr. Terry M. Townsend, President of the New York State Medical Society.

January 11th—Address by Dr. William J. Dieckmann, Attending Obstetrician, Chicago Lying-In Hospital, on "Eclampsia", illustrated by moving pictures.

February 5th to 10th inclusive—Medical Exhibit for the laity. Nationally known speakers will address lay audiences each evening during this period.

March 14th—Address by Dr. W. Wayne Babcock, Professor of Surgery, Temple University.

April 11th—Program under auspices of Lung Committee of Essex County Medical Society:

1. "Clinical Aspects of Pulmonary Abscess", by Dr. Harry Wessler.
2. "Clinical Aspects of Bronchiectasis", by Dr. J. B. Amberson, Professor of Medicine, Columbia University.
3. "Clinical Aspects of Carcinoma of the Lung", by Dr. George Ornstein, Professor of Medicine, Flower Hospital Medical College.
4. "Surgical Aspects", by Dr. William Reinhardt, Associate Professor of Surgery, Johns Hopkins University.

Discussions opened by Drs. Richard Dieffenbach and Irving Applebaum.

May 9th—Annual meeting. Election of Officers and Delegates.

MEETING ROOM

A nicely painted sign requesting *No Smoking* was displayed at the meeting and everyone obeyed. It made the auditorium a much pleasanter place in which to spend a few hours. Good work. Keep it up!

The new microphone surely has added much to the broadcast of the speaker's voice. Those in the rear of the hall can now hear. Thanks to the Academy for its installation.

The new teletype call system brings us nearer

to the perfect mark. You can now be called without disturbance to the rest of the assembly.

The following were elected to membership:

Active—

Cameron, Arthur E., Newark
Carpenter, Charles A., East Orange
Charbonneau, E. C., East Orange
Coleman, R. M., East Orange
Lamkin, Samuel, Newark
McGuire, John J., Newark
Shaul, John F., Bloomfield
Vincent, Nicholas F., East Orange

Transferred—

Jackson, G. H., from Union County
MacMillan, C. W., Montclair, from Passaic County

Associate—

Albano, Frank J., Newark
Anderson, William A., Bloomfield
Brancone, A. M., Bloomfield
Butan, Louis, West Orange
Fischbein, M. M., Irvington
Frame, Dorothy L., Bloomfield
Hartman, W. L., Jr., South Orange
Haschec, Walter, Newark
Leff, William A., South Orange
Levin, Murray, West Orange
Matheke, Otto G., Newark
Mitchell, W. L., Newark
Rommer, J. Jay, Newark
Rosenthal, Oscar J., Newark
Strauss, Leo M., East Orange
Valentin, Irmgard, East Orange
Wiener, David, Newark

was discussed by Drs. Yaguda, Applebaum and Willey.

The program of the Academy of Medicine of Northern New Jersey for December is as follows:

Meetings of the Sections—

CouncilThursday, Dec. 7, 1939
Eye, Ear, Nose and Throat...Monday, Dec. 11, 1939
Medicine and Pediatrics....Tuesday, Dec. 12, 1939
State MeetingThursday, Dec. 21, 1939
Surgery Tuesday, Dec. 26, 1939

Eye, Ear, Nose and Throat Section, Monday, December 11, 1939, 8:45 p.m.—

Paper: "The Handling of Vitreous and Iris Prolapse in Intraocular Operations."

Daniel B. Kirby, M.D., Assistant Clinical Professor of Ophthalmology, College of Physicians and Surgeons, Columbia University.

Medicine and Pediatrics, Tuesday, December 12, 1939, 8:45 p.m.—

Paper: "Food Allergy and Modern Aspects of Therapy."

Albert F. R. Andresen, M.D., Professor of Gastroenterology, Long Island College of Medicine.

Stated Meeting, Thursday, December 21, 1939, 8:45 p.m.—

Paper: "Septicemia."

Frank Lamont Meleney, M.D., Assistant Professor of Surgery, College of Physicians and Surgeons, Columbia University.

Surgery, Tuesday, December 26, 1939, 8:45 p.m.—

Clinical Meeting. Cases and papers by the surgeons of the Newark Hospitals.

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, October 19th, 1939, at the Academy Building, 91 Lincoln Park, South, Newark.

President Charles M. Robbins called the meeting to order at 9 p.m. He announced that the Academy was a co-sponsor of the newly created Town Hall of Essex County, and said he hoped that the Fellows would support this educational community project. He requested the audience to refrain from smoking in the auditorium because of the fire hazard.

The minutes of the May stated meeting were read and approved.

The tellers of the election declared that all the ballots were in the affirmative. The President announced the following duly elected:

Harold S. Connamacher, M.D., Newark, Fellow
George Paul Kocck, M.D., Newark, Junior Fellow.

Dr. Robbins introduced the guest speaker, Dr. William Goldring, Associate Professor of Medicine, New York University College of Medicine.

Dr. Goldring's paper, "Clinical Aspects of Hypertension and Arterial Heart Disease", reviewed the modern medical and surgical treatment and was very interesting to the large audience. The paper

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Doctors in New Jersey provided free medical care for numerous needy families last year and they are prepared to see that a physician is available in the future for all cases of genuine need, Dr. Watson B. Morris, of Springfield, President-Elect of the State Medical Society, declared before the members of the *Gloucester County Medical Society* at their Annual Banquet and Ladies' Night at the Pitman Country Club on the evening of October nineteenth.

Eighty physicians and guests attended the affair, among the later being delegations from the Camden and Salem Societies, and also other representatives of the State Society. Dr. Herman W. Wright, of Pitman, President of the County Society, was toastmaster.

Dr. Morris spoke briefly and congratulated the Gloucester County Society upon having the most successful social functions among similar societies in the State. He also said that members of the society have made valuable contributions to the advance of medicine.

Don Rose, Philadelphia columnist, interspersed wit with sage bits of philosophy in a talk following the dinner.

Dr. Chester I. Ulmer, of Gibbstown, Secretary of the society, made the annual presentation of the society's "achievement award", a mirth-provoking feature at these annual affairs of the doctors.

Music for the dinner was furnished by the Fuhrman Trio, which also played for dancing which followed the speaking. The committee on the meeting comprised Dr. Baxter A. Livengood, Dr. Fuller G. Sherman, and Dr. Frederick G. Wandall.

HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, October 3rd, 1939, at the Carteret Club, at 9:30 p. m., with Vice-President, Dr. George Ginsberg, presiding in the place of President James F. Norton, who is in St. Francis Hospital with a broken leg.

On motion of Dr. Londrigan, the society voted to send a basket of fruit to Dr. Norton.

NECROLOGY

The following members of the society have passed on since our last meeting, and the members were asked to stand for one moment in silence as tribute to their memory:

Dr. William Freile	Dr. George Wilkinson
Dr. Levings A. Opdyke	Dr. David M. Marks
Dr. Louis J. Ferenczi	Dr. Lewis Mendelsohn

FALL CLINICAL CONFERENCE

Dr. S. A. Cosgrove announced that The Medical Society of New Jersey last year began a series of Annual Clinical Meetings, the first of which was held in Essex County. This year Hudson County will provide the program and entertainment for a similar meeting on November ninth and tenth.

The following committees on the Conference have been appointed:

GENERAL COMMITTEE

Frank J. McLoughlin—St. Francis Hospital
 Lucius F. Donohoe—Bayonne Hospital
 Thomas McG. Brennock—Greenville Hospital
 George O'Hanlon—Jersey City Medical Center
 James L. Cobham—Christ Hospital
 Edvard G. Waters—Margaret Hague Maternity Hospital
 Berthold S. Pollak—Hudson County Tuberculosis Hospital
 J. Lawrence Evans—North Hudson Hospital
 Louis Pyle—Fairmount Hospital
 Joseph F. Londrigan—St. Mary's Hospital
 William J. Monaghan—Hudson County General Hospital
 Roland J. Lynch—Hudson County Hospital for Mental Diseases
 Ernest H. McDede—West Hudson Hospital

This committee has already met and virtually all of the hospitals have promised coöperation.

The following sub-committees have been set up:

COMMITTEE ON PROGRAM

Earl J. Halligan, Chm.	S. R. Woodruff
T. J. Schuck	L. V. Lindroth
Edgar Burke	Hyman Borshaw
T. J. White	A. J. Conty
Herman Jaffe	Thomas J. Keegan

COMMITTEE ON DINNER

George Ginsberg, Chm.	C. B. Kelley
N. M. Alter	J. P. Stout
W. M. Doody	W. J. Snyder
Julius Heilbrunn	J. A. Murray

COMMITTEE ON TRANSPORTATION

V. J. Sheeran, Chm.	Charles Sirken
E. J. Chapman	Herman Behrens
J. S. Madaras	W. J. Gleeson
E. M. Kiely	Maurice Shapiro

COMMITTEE ON REGISTRATION AND RECEPTION

Henry Spence, Chm.	J. I. Berlin
C. M. Bahnson	S. I. Koopferstein
J. N. Connell	P. E. Maras
H. C. Benjamin	R. L. Ballinger

COMMITTEE ON CORRESPONDENCE AND PUBLICITY

H. H. Tyndall, Chm.	L. L. Perkel
W. M. Barbarito	M. T. Long
V. P. Butler	W. L. Williamson
A. E. Jaffin	A. A. Mutter

The general program is to have the mornings devoted to wet clinics, operative clinics, case presentations, etc., at the several hospitals, and to endeavor to have the work departmentalized in General Surgery, General Medicine, Pediatrics, Industrial and Traumatic Surgery, Neuro-Surgery, Bronchoscopy and Chest Surgery, Obstetrics, Urology, and Psychiatry.

Each afternoon there will be a general meeting at which the staffs of the several hospitals will present cases at dry clinics. The guest speaker at the Evening Dinner on Friday will be Dr. Morris Fishbein, Editor of the Journal of the American Medical Association.

COMMITTEES

The Secretary announced that the following regular committees of the society had been appointed by President Norton:

Post-Graduate Committee (3 years to 1942)

T. J. White, Chairman	A. Justin
W. L. Williamson	F. A. Barone
E. Halligan	

Welfare Committee (3 years to 1942)

T. J. Schuck, Chairman	E. Alpert
M. Shapiro	

Public Health Committee (3 years to 1942)

S. Chayes	L. A. Schneider
C. J. Larkey	E. M. Kiely
R. J. Doran	H. Branch
G. Piltz	

Scientific Committee (to serve 1 year)

N. M. Alter, Chairman	N. Meyerson
B. S. Pollak	

Publicity Committee (3 years to 1942)

W. J. Snyder, Chairman (to serve 1 year)	
A. C. Ruoff	

Membership Committee (to serve 1 year)

W. T. Callery, Chm.	J. J. Federer
V. P. Butler	H. R. Dukes
L. K. Madison	P. Kresch
D. M. Kiely	D. I. Nalitt
N. Rowe	J. L. Hollywood
S. A. Cosgrove	H. A. Cranelli
W. J. Gleeson	P. A. Simeone
E. V. Rundlett	W. D. Weber
M. Flichtenfled	H. L. Taft
H. Spence	J. J. Quinn

Medical Economics Committee (3 years to 1942)

J. L. Evans, Chairman	A. A. Mutter
E. A. P. Peters	L. A. Schneider
E. G. Waters	E. J. Chapman
M. Frank	H. Tyndall
O. H. Mustermann	

MISCELLANEOUS COMMITTEES

To serve During Dr. Norton's Term of Office

Medical Defense Committee

A. C. Ruoff, Chairman	T. J. Schuck
E. Alpert	

Veneral Disease Committee

V. P. Butler, Chairman	S. R. Woodruff
E. J. Daly	F. F. Haggerty
M. Shapiro	N. Meyerson
J. J. O'Connor	E. J. Connell
I. Markowitz	H. R. Dukes

Cancer Committee

R. L. Ballinger, Chm.	J. B. Faison
M. A. Swiney	R. J. Doran
D. D. Dougherty	A. J. Walscheid

Hudson County School Physicians Committee

J. Schapiro, Chairman	T. H. Elsasser
F. J. Pflug	J. A. Angelo
I. Pyle	S. Chayes
C. E. McNeeney	S. Selinger

ELECTION OF NEW MEMBERS

The following physicians were elected to membership:

Nunzio Joseph Carrozzo, North Bergen
Daniel Davis, Jersey City
Vincent J. Felitti, North Bergen
Victor Low, Jersey City
Samuel S. Markell, West New York

Six applications for membership were received.

SCIENTIFIC

Dr. Watson B. Morris, President-Elect of The Medical Society of New Jersey, gave a five-minute report of the activities of the State Society, stressing the work that is being done on the following:

1. Proposed Sickness or Indemnity Insurance.
2. Changes in the Compensation Law.
3. Committee on Hospital Relationship.
4. The National Health Program.

Dr. Ginsberg introduced Dr. Emil Novak, Associate Gynecologist, Johns Hopkins Medical School, Baltimore, whose subject was "Endocrine Aspects of Gynecology".

Discussors: Drs. S. Cosgrove, R. Ballinger and J. Swiney, terminated by Dr. Novak.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

The September meeting of the *Monmouth County Medical Society* was held on Wednesday evening, September 27th, 1939, at the Berkeley-Carteret Hotel, Asbury Park.

SCIENTIFIC

Dr. Nichols spoke on the New Jersey Health and Welfare Conference, which has been called by Governor Moore, and how it will affect the practice of medicine in New Jersey.

Dr. Elton W. Lance spoke on voluntary health insurance.

MEMBERSHIP

Two applications for membership were received and referred to the Board of Censors.

COMMITTEES

The following committees were appointed by President MacKenzie:

The following committees, modelled after those of the State Society, were appointed:

AUDITING

J. B. Makin	George Reynolds
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PROGRAM AND SCIENTIFIC WORK

James P. Pregnall, Chairman

C. A. Pons	C. C. Perrine
H. B. Mason	Howard Pieper
Joseph Wiener	Ellsworth F. Baker
Harry Brindle	

PUBLIC RELATIONS

C. Byron Blaisdell, Chairman

W. H. Fairbanks	Martin A. Quirk
Stanley Nichols	F. Bullwinkel
James A. Fisher	Joseph Jordan
William G. Herrman	

MEDICAL PRACTICE

O. R. Holters, Chairman

Joseph Binder	Stephen Sewell
Emerson Haines	Ernest A. Robinson
R. B. Wilson	

SCHOOL PHYSICIANS

Samuel Edelson, Chairman

R. E. Watkins	Ralph Woodruff
C. D. Prout	S. L. Neiderhoffer

INDUSTRIAL AND TRAFFIC PROBLEMS

D. F. Featherston, Chairman

O. W. Hyer	J. W. Hardy
Karl F. Metzger	

MEDICAL CARE FOR INDIGENT AND LOW-WAGE GROUP

S. W. Hausman, Chairman

W. A. Rullman	W. K. Campbell
H. W. Ingling	S. O. Wilkins

PUBLIC HEALTH COMMITTEE

Stanley Nichols, Chairman

SUB-COMMITTEES ON PUBLIC HEALTH COMMITTEE

Maternal Welfare	Pneumonia Control
Wm. Heatley, Chm.	Louis Albright, Chm.
K. G. Brown	H. H. Freedman
F. J. Goff	
William Shanik	Venereal Disease
Donald Reynolds	D. M. P. Magee, Chm.
	J. C. Clark
Tuberculosis	A. J. Perrotta
Frank Altschul, Chm.	James W. Parker
Paul K. Bornstein	A. Downey Osborn
J. F. S. Carter	
George McDonnell	Adult Health
W. G. Herrman	J. C. Clayton, Chm.
	Robert Leighton
Crippled Children	Franklin Wilbur
B. W. Moffat, Chm.	E. G. Dewis
Jos. G. Villapiano	J. George Feman
Cancer Control	Pediatrics
Harold Kazman, Chm.	Murray Woronoff, Chm.
O. R. Holters	William Von Oehsen
Maxwell Colby	S. S. Ellenson
Gregory Sacco	I. K. Lovett
L. L. Leonard	
Robert S. McTague	Mental Hygiene
Victor Knapp	C. C. Graves, Chm.
	C. M. Trippe
	R. Pietri

EXECUTIVE COMMITTEE

A meeting of the Executive Committee was held on Monday evening, September 11th, 1939, at the Monmouth Memorial Hospital.

The question of advertisements in the Monthly Bulletin was discussed, and the majority of the members felt that they might as well be continued to help support the cost.

The revision of the Constitution was taken up by Dr. Blaisdell, as a member of that committee. Copy of the Constitution, together with a copy of the contemplated changes, was ordered sent to each member of the Executive Committee for consideration.

The following letter was addressed to the County Medical Society members by the President, R. A. MacKenzie:

"With this month the Medical Society resumes its stated meetings and other activities. It is to be hoped that the summer recess has been pleasant and relaxing. There is need now for the participation of every one of our members in the society program. Regular attendance at the meetings is of first importance.

"Every member realizes the significance and seriousness of the times in which we live. The past few years have brought changes in such number and import that full appreciation is difficult. Our profession has been troubled by disputation within, and coercion from without. In the immediate future the battle lines which have been drawn will move into action. Public health issues are in the forefront of plans for both major political parties in the next election. Medical practice as we know it faces a fight for survival. Against common en-

emies we doctors should form a united front, submerging lesser interests.

"Our objectives in the Monmouth County Medical Society for the coming year, therefore, are the strengthening of our fellowship and scientific attainment, and the clarification of our privileges and duties in an individualistic profession, including not only acquiescence but leadership in a sane program to provide medical care for the indigent and low-wage group.

"Finally we must win the friendly understanding and coöperation of thinking people outside of our ranks. In these aims we keep step with other County and State Medical Societies throughout the nation.

"The increasing toll of traffic accidents, and the rôle of defective vision, the influence of alcohol, and other medical or health considerations therein, have the attention of a State committee. Our County Committee on Industrial Problems now includes Traffic Accidents, and should have opportunity at the shore to contribute in a valuable way to this important study."

OCEAN COUNTY

L. R. Carmona, Reporter

The regular monthly meeting of the *Ocean County Medical Society* was held at the "92" Inn, Lakewood, N. J., October 12, 1939, at 8 p. m. The meeting was called to order by the President, Dr. Obert, with the following members present: Drs. Obert, Birach, Herberner, Tillies, Sickel, Dodd, McIlvaine, Goldstein, Towbin, Buermann, Carmona, Sawyer, Wittie, Thompson, Szold, Green, Taylor, Hogan, and Gaumer; and Dr. Smith as a visitor.

INDIGENT CASES

The matter of indigent patients sent to various hospitals and clinics was brought up again. After a lengthy discussion upon the committee report relative to the procedure of referring indigent cases to hospitals and clinics, a motion was made by Dr. Taylor, seconded by Dr. Goldstein, and carried: "That all indigent cases should be referred to hospitals and clinics, by the family physician on a regular form supplied by the Ocean County Department of Health. The form should show, besides the physical examination, diagnosis, and recommendation, the family income, and the inability of indigent cases to pay." It was also moved to see Mrs. Brown, of the Department of Health, to supply these forms.

To overcome the erroneous idea among the public that physicians and surgeons are paid by the county for their services in treating indigent cases in the hospital, Dr. Taylor presented a form to be given to these indigent cases upon leaving their hospitals and clinics stating that the doctors have done their work free of charge. The form was approved, and ordered to be printed and distributed to the several hospitals and clinics.

FIELDS OF HEALTH ORGANIZATIONS

President Obert opened a discussion as to the advisability of this society forming a committee

and requesting the formation of similar committees from the Board of Frecholders, the Ocean County Health Department, and the Ocean County Health Association, all to meet and devise ways and means of eliminating costly overlapping of the activities of the organizations. After discussion the matter was tabled.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Passaic City Club, Passaic, October 12th, 1939, at 9 p. m., with President Wayne W. Hall, M.D., presiding.

NEW MEMBERS

The following members were elected:

Active membership—

William A. O'Brien, M.D., Passaic

Associate membership—

Abraham Schechtman, M.D., Passaic

PUBLIC RELATIONS

In the absence of Dr. Walker, Chairman of the Public Relations Committee, Dr. Vanderbeck presented the report of that committee:

1. That the telephone directory was being studied as to listings.

2. Talks to lay groups were being arranged, and arrangements are going on with Station WNEW for definite talks on preventive medicine and medical advances.

3. Paid advertising will be started next month. Ten articles, one every other week, will be published in the daily newspapers in Passaic County.

SCIENTIFIC

Two papers were presented by the guest speakers on the subject of sterility:

Dr. E. K. Brunner, Instructor in Obstetrics and Gynecology, New York University College of Medicine, spoke on the subject "The Endocrine Aspect of Female Sterility".

The Assistant Visiting Surgeon in Urology, New York and Bellevue Hospitals, spoke on "The Endocrine Aspect of Male Sterility".

SUSSEX COUNTY

Edward K. Hawke, M.D., Reporter

A business meeting of the *Sussex County Medical Society* was held at Sussex Inn, Sussex, N. J., on Wednesday, October 11th, 1939, at 9:30 p. m. Dr. A. H. Groeschel, President, presided. Fifteen members were present, with Dr. Spurgeon, Resident Physician, Newton Memorial Hospital; Dr. E. J. Marsh, Second Vice-President of the State Society; Mrs. A. J. Casselman, from the State Woman's Auxiliary; and Dr. Renner, representing the same organization, as guests.

WOMAN'S AUXILIARY

Mrs. Casselman spoke on the reasons for organizing a Woman's Auxiliary to this society, and gave the aims and work accomplished by such a body. She stated that this organization was in line with the policies of the A. M. A. and State Society.

Later in the meeting a motion to form a Woman's Auxiliary was voted down as it was felt there were no plans or objectives to justify its existence.

ADDRESS OF DR. MARSH

Dr. Marsh, representing Dr. Hawkes, the State Society's President, gave an interesting talk on the objectives of the present administration. These were essentially to consolidate and strengthen recent gains in legislative and public health matters; to procure medical aid for the indigent as an obligation of the public; and to provide for voluntary health insurance on a non-profit basis. He briefly discussed each of the above programs, and gave a general idea of what we might expect from our State Society during the coming year.

BABY KEEP-WELL STATION

The matter of having a physician assigned by the County Society to the Baby Keep-Well Clinic in Newton and paid by the State was voted down as inadvisable due to similar experiences in the past.

VENEREAL DISEASE CLINICS

The society was notified by letter from Dr. Mahaffey, Director of the State Department of Health, that the plan to have seven centers for venereal disease clinics would have to be reduced to five because of shortage of funds. Vernon and Ogdensburg were eliminated, while the following were accepted: Branchville, Franklin, Sparta, Newton, and Sussex. It was voted to accept this tentatively, though still recommending inclusion of the other two towns.

NEW MEMBER

Dr. Clifford M. Schmidt, of Newton, was accepted as a member of the society on transfer from Kootenai (Idaho) County Medical Society.

DUES

It was voted to have the County Society dues reduced to \$2.00 for the ensuing year due to a cash balance of \$101.70.

POST-GRADUATE LECTURES

It was voted to secure the series of post-graduate lectures through Rutgers University. There will be six lectures,—three each at Newton and Franklin Hospitals, the course to be started within four or five weeks.

PUBLIC RELATIONS

The newly formed Public Relations Committee was directed to prepare a plan of action for the Society and present it at the next meeting.

The Secretary was instructed to ascertain from the various candidates for legislative State offices in the coming November election their position in regard to organized medicine as opposed to the various cults and irregular practitioners.

Adjournment was voted at 12:15 a. m. and a luncheon followed.

The next meeting will be held on January seventeenth.

THE WOMAN'S AUXILIARY

GREETINGS TO AUXILIARY MEMBERS

By MRS. G. E. McDONNEL, President, Mount Holly, N. J.

In 1917 the wives of the members of the Dallas, Texas, Medical Society met and organized the first State Auxiliary. Since then many other States have followed suit and ten years later New Jersey formed its first organization under the leadership of Mrs. A. H. Lippincott. From then until the present time many able women have guided the helm of this ship.

The Auxiliary has admirably fulfilled its social functions. Wives have become better acquainted, many difficult situations have been eased, and attendance at medical meetings has increased.

Members of auxiliaries, as organized groups, soon discover that meeting simply in a social way does not create sufficient satisfaction to hold them together. There must be activities in which they can participate. Thus many of our counties have developed philanthropic functions. These are very admirable and keep the group interested.

The laity requires education, but it should be given through the Medical Profession so there may be rational control of what the public thinks and does, in health activities. The most important objectives of an Auxiliary are to direct public thinking and activities in the channels which the Medical Profession desires, and to extend authentic information on health.

Therefore, I urge you to become acquainted with the health activities of the woman's clubs in your communities.

A well-schooled Auxiliary group reaches out into every phase of woman's organization work. The doctor's wife takes part,—and generally a prominent part,—in public welfare, and in Parent-Teacher and Federated Club work. The health programs of these groups become more extended each year. The doctor's wife as a member of the board or worker in one of these organizations can become a liaison between the group and the Medical Profession. We are called upon to do a particular thing this year in interesting our husbands in the Society for Widows and Orphans. No better philanthropy exists in our State. When you get your husband to join, you help not only yourself, but someone less fortunate than you. Let me urge you to secure memberships in this very worthwhile organization. *Mrs. George Scheller, 88 Tracy Avenue, Newark*, is Chairman for Widows and Orphans, and can furnish you with the details.

Contact your respective Medical Societies for definite plans and assume no new activity without the consent of your Advisory Committee.

MRS. G. E. McDONNEL, President.

WOMAN'S AUXILIARY EXECUTIVE BOARD

Reported by Mrs. Banks S. Baker, Recording Secretary

The regular meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held at the Walt Whitman Hotel, Camden, on Monday, October 9th, 1939. The meeting was called to order at 10:15 a. m., by the President, Mrs. G. E. McDonnel. The attendance was as follows:

Board members	22
County Presidents	8
Visiting members	17
Guests	4
—	51

The Treasurer, Mrs. R. P. McConaghy, submitted a report showing a balance of \$601.68.

A letter was read from Mrs. Lucius Cole, Na-

tional Corresponding Secretary, stating that a meeting of the national Board will be held in Chicago on November 17.

Mrs. C. Chester Chianese, Chairman of the Archives Committee, reported that all valuable documents, letters, etc., have been filed in Trenton. She requested information as to the whereabouts of the scrapbooks from 1936 which had been prepared by the State Publicity Chairmen.

Mrs. Ily R. Beir, Chairman of the Committee on Arts, Hobbies, and Medical History, submitted a report of the work done to date. In recent years the Medical Society has given the Auxiliary certain important tasks, and the work has apparently been done to its liking. As a result the Auxiliary is to be entrusted with more work. Because the

annual meeting of the A. M. A. will take place in New York City next year, Mrs. Beir expressed the hope that the Art, Hobby, and Medical History work will provide a goodly portion of our exhibit there.

Mrs. David B. Allman, Chairman of the Entertainment Committee, submitted a brief outline for the coming convention.

Mrs. Chester I. Ulmer, Chairman of the Finance Committee, presented the proposed budget for 1939-1940. The President read a report regarding our allotment of \$250 from the State Medical Society.

Mrs. A. J. Casselman, Chairman of the Committee on Organization, submitted a letter from the Monmouth County Medical Society regarding the disbanding of the Auxiliary in that county. Mrs. Rollo K. Packard, of Chicago, President of the Auxiliary to the A. M. A., was asked for suggestions, and commented briefly. Mrs. Casselman also submitted a letter asking the Organization Chairman to talk to the Sussex County Medical Society about organizing an Auxiliary in that county (p. 691).

Mrs. A. H. Lippincott, Chairman of the Public Relations Committee, stated that her entire program has been printed in the "1939-1940 Program". She urged all Public Relations Chairmen to have the Auxiliary book list posted in the libraries.

Mrs. George Scheller, Chairman of the Committee on the Relief of Widows and Orphans, submitted her report. Dr. E. Z. Hawkes, President of The

Medical Society of New Jersey, urged the members of the Auxiliary to support the organization.

Mrs. Don Epler reported that the "1939-1940 Program" is ready for distribution. She has written the County Presidents relative to their membership, and to date 1,099 programs have been requested. There are 1,409 members on our roster.

The programs of the Auxiliaries of the following counties were presented: Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Ocean, Union and Passaic.

Mrs. Max Weiman, President of the Camden County Auxiliary, gave a report of the State Federation Conference.

The President suggested that every committee chairman,—state and county,—keep a notebook which could be handed on to her successor. Mrs. Carlander felt that if a fairly good notebook was given to each chairman, she would feel more responsible for it, and moved that the President purchase these notebooks and give them to each committee chairman. Seconded and carried.

Mrs. Allman moved that a letter of condolence be sent to Mrs. Friele. (Obituary of Dr. William Friele, Journal, September, 1939, p. 567.) Seconded and carried.

Following luncheon, Mrs. Packard addressed the members; and Dr. LeRoy A. Wilkes spoke briefly on Public Relations.

On motion the meeting adjourned.

Atlantic County

Reported by Mrs. Samuel L. Winn

The first regular meeting of the 1939 and 1940 regime of the *Woman's Auxiliary to the Atlantic County Medical Society* was held Friday evening, October 13th, 1939, at the Hotel Ambassador, with twenty-one members and two guests present.

This being the first meeting, very few committees were in readiness for reports of their endeavors. However, the evening was well spent. Mrs. McDonnell, our State Auxiliary President, and Mrs. Hornberger, State Corresponding Secretary, greeted us with inspiring messages.

Assemblyman Frank G. Farley gave us a most interesting talk on Constructive Legislation.

Mrs. Ruffin Stamps, who is Chairman of the Legislative Committee, voiced the plan of our Auxiliary to organize a Legislative Study Group, which will convene after each regular meeting.

Our guest speaker for the November meeting will be Dr. Chester I. Ulmer. Topic: "How to Get Sick".

Burlington County

Reported by Mrs. Dean H. Le Favor

The regular meeting of the *Woman's Auxiliary to the Burlington County Medical Society* was held October 2nd, 1939, at 1:30 p.m., with Mrs. C. V. Wells presiding, and fifteen members present.

We donated \$50.00 to the County Parent-Teachers Association to be used in the purchase of resusci-

tators for the Burlington County Hospital, Mt. Holly, and Zurbrugg Memorial Hospital, Riverside.

We are sponsoring another student nurse who is now in training at the Pennsylvania Hospital, Philadelphia, and who is unable to finance her own course of study.

Our hostess, Mrs. Luther Hartman, of Maple Shade, served refreshments after the meeting.

Camden County

Reported by Mrs. Magdalena W. Hirst, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held Tuesday, October 3, 1939, at 2 o'clock at the home of the President, Mrs. Max L. Weimann, who presided. There were forty-five members present.

The Program Chairman, Mrs. Lawrence L. Glover, reported plans for the coming meetings of the season.

Meetings will be held as follows:

January 6, with a guest speaker on "Medical Social Work".

March 4. The annual Card Party.

March 5. A regular meeting at the home of Mrs. Wesley Jack, to be followed by an entertainment.

March 26. Public Relations Meeting.

May 9. Annual Luncheon and entertainment.

Mrs. Lawrence Glover presented the program for the day with three guest speakers on the timely subject "The International Situation".

Miss Ruth M. Outland, Principal of the Friend's School of Haddonfield, N. J., who recently returned after spending the summer in Germany, spoke on her observations while doing refugee work in Berlin.

Mrs. Edward Catlett, who has just returned to Haddonfield after more than a year's stay in England, and whose two children attended school while there, talked on education and habits of the English people. She exhibited a gas mask, and the school uniforms worn by her children—girl's consisting of white, green-figured dress, tan blazer and straw hat; the boy's was a red coat and cap each bearing insignia of the school. The Boy Scout Cub suit made up of a sweater, a scarf of the school colors, and a cap.

Richard Wood, of Philadelphia, the representative of the Friend's Peace Committee on the National Peace Conference of New York, discussed the six points of the National Peace Conference:

1. Keep the United States out of war.
2. Initiate continuous conference of neutral nations to procure a just peace.
3. Work for permanent world government as the basis of peace and security.
4. Prevent exploitation of war for private gain.
5. Recognize and analyze propaganda to prevent warped judgments and unjust animosities.
6. Strengthen American democracy through solving pressing domestic problems and vigorously safeguarding civil liberties.

Tea was then served with Mrs. Gordon F. West, Hospitality Chairman, in charge. Mrs. Edward Pechin, wearing a Swedish costume, and Mrs. A. M. Elwell, in the dress of Finland, poured.

Other very beautiful costumes were: Turkish, worn by Mrs. O. W. Saunders; Norwegian, by Mrs. Edgar Howard; Bavarian, by Mrs. B. Baker; Mexican, by Mrs. V. T. McDermott.

These costumes were beautifully embroidered, trimmed with hand-made laces, and hand-painted, and had been collected in European countries and very kindly furnished by Mrs. Joseph Tatem, of Haddonfield, N. J.

Hudson County

Reported by Mrs. Sydney Chayes

The *Woman's Auxiliary to the Hudson County Medical Society* opened its season's activities on Monday, October 2nd, 1939, at the Jersey City Y. W. C. A.

A Board Meeting was held in the morning, followed by luncheon for fifty members, with our new members being guests of honor.

This is the Auxiliary's twelfth anniversary; and Mrs. Samuel Scott, Co-chairman of Membership, introduced twelve new members. Our newly elected President, Mrs. Arthur Largay, cordially welcomed and presented each new member with a red rose, symbolic of friendship.

Following luncheon, the minutes of the previous meeting were read by the Recording Secretary, Mrs. Bernard Kelly, followed by reports from the Treasurer, Mrs. Harry Perlberg; Program, Mrs. Joseph Ruvane, and Librarian, Mrs. William Friele. The remainder of the afternoon was spent in playing cards.

Ocean County

Reported by Mrs. Emanuel M. Sickel

The regular meeting of the *Woman's Auxiliary to the Ocean County Medical Society* was held Friday afternoon, October 7th, 1939, with Mrs. A. Goldstein presiding. There were eight members present, and one guest from the Burlington County Auxiliary.

Reports were received from the Secretary, Mrs. William Dodd; Public Relations Chairman, Mrs. Robert Buerman; Ways and Means Chairman, Mrs. Leon Taylor; and Program Chairman, Mrs. Fred Bunnell.

The program for the year, though not complete at this time, promises to be interesting and replete with talks to be given by prominent speakers. The definite plans of all committees have not yet been placed before the open meeting, but we have the assurance that every committee is an active one.

At this meeting our guest speaker was Mrs. Howard Hornberger, of Roebling, N. J. Mrs. Hornberger stressed in particular the necessity for concerted interest in the Widows and Orphans Committee.

Besides those already mentioned there were present Mrs. Edwin Obert, of New Egypt, and Mrs. Emanuel M. Sickel, of Lakewood.

After the adjournment of the business meeting, tea was served by our hostess, Mrs. Fred Bunnell, of Barnegat.

Somerset County

Reported by Mrs. Bernice P. Gray, Recording Secretary

The regular meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held October 12th, 1939, with Mrs. E. G. Brittain presiding, and eighteen members present.

Reports were received from the Committees on Program, Mrs. E. T. Flint; Medical History, Mrs. L. Ely; and Widows and Orphans, Mrs. A. L. Stillwell.

Routine business was transacted.

No program.

After the meeting the Auxiliary members joined the Medical Society for luncheon.

Union County

Reported by Mrs. Rowland P. Blythe

Chairmen and members of committees were named and plans for various activities for the ensuing year were discussed at the meeting of the *Woman's Auxiliary to the Union County Medical Society* on the evening of September 20th, 1939, at the St. Elizabeth Hospital, Elizabeth.

Mrs. Carl G. Hanson, of Cranford, was named chairman of arrangements for a tea to be given for new members. The Treasurer, Mrs. L. Victor duBusc, of Elizabeth, reported that we have deposited \$100 toward our "Student Fund".

The President, Mrs. Herschel S. Murphy, of Roselle, conducted the meeting, after which refreshments were served in charge of Mrs. George Knauer, of Elizabeth.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XII

November, 1939

No. 11

PHRENIC nerve interruption in the treatment of tuberculosis has lately lost much of its former popularity. By some it is condemned as being practically useless, if not actually harmful. A more discriminating judgment of this operation is urged by J. W. Cutler who has analyzed 122 consecutive phrenic nerve interruptions in his private patients.

PHRENIC NERVE INTERRUPTION

Claims concerning the value of phrenic nerve interruption are contradictory and confusing. One author reviewed 78 reports involving a total of 7,435 operations performed as an independent procedure and found "cures" reported in 23%. On the other hand, Coryllos, citing his own experiences and those of several workers abroad concluded that the operation is "not efficient, not without danger, and causes a loss of precious time."

This wide divergence of opinion is in good part explained by the type of patient treated—phenomenally good results are in relatively early cases and they would undoubtedly have been obtained from bed-rest alone, while in far advanced cases and in the presence of large, thick-walled cavities success can rarely be expected.

In a consecutive series of 122 tuberculous patients on whom phrenic nerve interruption was performed, it was done on 106 as an independent collapse measure. Many stages and varieties of tuberculosis are represented. Sexes are about equally distributed. The operation was done 60 times on the left side and 62 on the right. In 65 the interruption was temporary, in 57 permanent.

Evaluation of the operation should be based primarily on the changes that follow in the lung under consideration, as determined primarily by comparative X-ray findings, and not necessarily upon the ultimate fate of the patient. The time element, following operation, is of extreme importance. The good results of phrenic nerve interruption become evident within the first six months. Late results are more difficult to define; therefore, a three-to-five-year post operative interval, as a basis for late results, is not unreasonable.

The evaluation of phrenic nerve interruption is discussed under four main headings: (1) the value

of the operation as an independent collapse measure, (2) the value as an adjunct to other collapse measures, (3) complications of the operation, and (4) temporary as contrasted with permanent phrenic nerve interruption, and their corresponding indications and contraindications.

In retrospect, the cases are classified as "apparently suitable" and "unsuitable." Unsuitable cases include: (1) apical cavities 3 or more cm. in diameter, for the operation is useless in the attempt to close apical cavities in which the apex has become more or less excavated and adherent to the thoracic wall; (2) dense fibrotic lesions with embedded cavities; (3) pneumonic consolidations; (4) acute infiltrations. In this series there were 30 patients with lesions deemed in retrospect as unsuitable for the operation. The contraindications, in the sense that no benefit will follow, cannot however be considered absolute for occasionally a distinctly good result will follow.

Seventy-one patients fell into the "apparently suitable" category and were evaluated as follows:

(a) *Unimproved*, 52%. No material X-ray evidence of improvement in the tuberculous lesions noted within 3 to 6 months after the operation, or an actual increase in the disease. Lack of improvement was observed in all kinds of cases with "apparently suitable" lesions, including both cases of early limited infiltrations without X-ray evidence of cavity and cases of advanced disease.

(b) *Improved*, 34%. Cavity was either closed or reduced in size or there was X-ray evidence of significant clearing with lessening of toxemia and improvement in well-being. However, in only 14 of the 24 cases in this group, did the improvement result in the stabilization of the lesion so that no further therapy was required. In the remaining

10, improvement, marked at first, was in time followed by serious relapse.

(c) *Cleared, 14%.* Clearing of the disease in the lung except for some fibrous strands and a few small, sharply defined, moderately dense, spots. There were cavities of varying sizes in 8 and infiltration without X-ray evidence of cavity in 2. The result followed so shortly after operation and in such manner as to leave little doubt that the paralysis of the diaphragm was the responsible factor. The lungs have remained clear over an average period of more than six years after operation.

No concrete conclusions could be reached as to the type of case among the "apparently suitable" patients in which the operation can be undertaken with reasonable assurance of success. Good results were obtained in advanced disease and in unexpected situations. On the other hand, failures were encountered in minimal cases. In general, good results were observed more frequently when the major lesion was situated below the clavicle, and when the cavity was isolated, thin-walled and surrounded by nearly normal lung tissue.

The relative value of phrenic nerve interruption as an alternative to artificial pneumothorax and thoracoplasty, is considered. In the majority of cases in which phrenic nerve interruption was used as an alternative to pneumothorax the operation was either a useless undertaking or relapse followed an initial improvement. In those cases in which bilateral pneumothorax ultimately became necessary, selective collapse could be established in only 12 out of 28 patients. Time wasted on phrenic nerve interruption was largely responsible for the formation of extensive adhesions. Phrenic nerve surgery should not be looked upon as a substitute for pneumothorax, but must be regarded as a supplementary form of therapy.

More serious is the question of phrenic nerve interruption in preference to thoracoplasty. Of 31 patients in this series suitable for an immediate thoracoplasty, but subjected to phrenic nerve interruption in the hope of avoiding thoracoplasty, 3 died from hemoptysis and 3 from progressive tuberculosis and 7 more became hopeless invalids. In retrospect, these tragedies might have been avoided had thoracoplasty been performed promptly when conditions were most favorable. The important thing is not to resort to a phrenic nerve operation when thoracoplasty is plainly indicated, and not to delay thoracoplasty beyond the time

when the phrenic nerve operation has accomplished its maximum good.

Phrenic nerve interruption was carried out also in 16 patients either as an adjunct to other collapse measures or in the treatment of certain complications of pneumothorax therapy including: ineffective pneumothorax, hemoptysis, troublesome cough, discontinued pneumothorax therapy, spontaneous pneumothorax, empyema cavities. The operation accomplished the desired result in about one-third of these patients.

Complications of phrenic nerve interruption must be taken into consideration. In the present series, significant complications attributable to the operation, were encountered in 6 with death in 2. Cardiac failure, which accounted for the 2 deaths, was the outstanding complication. Other important complications were interference with the cough mechanism (2 patients), gastric disturbance (belching and a sense of fullness in the stomach) annoying but not serious (3 patients). The fact remains, however, that the treatment of tuberculosis does not always permit a safe and sure choice of therapy. Phrenic nerve interruption may, in individual cases, prove to be accompanied by the least risk.

Both temporary and permanent phrenic nerve interruption have their place. A temporary phrenic nerve interruption is indicated (1) when the problem is of an emergency nature, as in hemorrhage or active disease requiring immediate collapse therapy when other collapse measures cannot be instituted at the moment, and (2) when other collapse measures such as pneumothorax or thoracoplasty, are in prospect. A permanent phrenic nerve operation is indicated when the operation is carried out as the sole therapeutic measure in the attempt to cure the patient after other collapse procedures have been considered unsuitable, or are plainly contraindicated.

The danger today is not that too many phrenic nerve operations will be performed or that they will be undertaken in an indiscriminate manner, but that the operation will be discarded. This would be unfortunate, for phrenic nerve interruption appears to have value in 15 to 25 per cent of patients. At times it may be the simplest means for saving a patient's life. The operation, however, should be restricted to properly selected cases.

Phrenic Nerve Interruption, J. W. Cutler, M.D., Amer. Review of Tuber., July, 1939.

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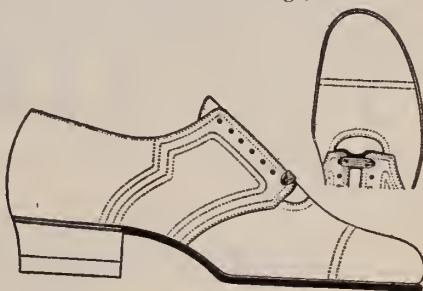
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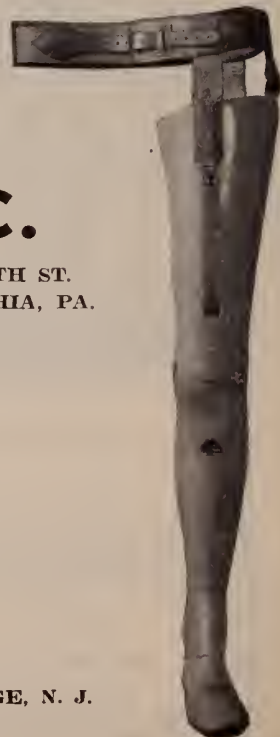
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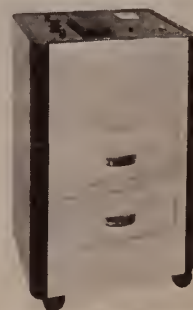
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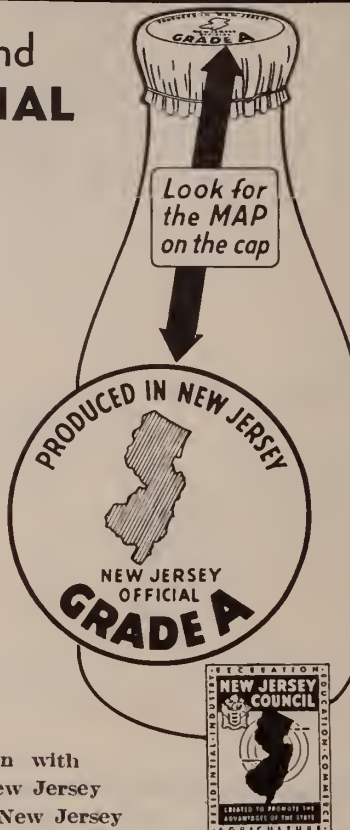
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A bambino from the Foundling Hospital, Florence, Italy,—A. della Robbia

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THE JOURNAL

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Editorial and Executive Offices of the Society
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The earliest techniques for determination of vitamin A were similar in that they all first provided for depletion of the body stores of vitamin A of the rat by restriction of the animals to basal rations free from or quite deficient in the vitamin. In the "rat growth" method, the vitamin A activity of the material under assay was estimated by feeding graded dosages to animals depleted of the vitamin (as gauged by cessation of growth) and recording the ensuing growth response (2). In the "curative technique," the incidence of xerophthalmia served as the criterion of vitamin A depletion (3), and vitamin A activity was estimated by determining the dosage of the test material necessary to establish cure of xerophthalmia.

Techniques were also gradually developed which in some instances embodied features of both the growth and curative methods. Still another technique based on the continuous appearance of cornified epithelial cells in vaginal smears—a further characteristic of vitamin A deficiency in female rats—was evolved (4). Further research showed that colorimetric and spectrographic methods may be adapted to the estimation of vitamin A activities of specific materials (5)

Of all methods for estimation of vitamin A in foods, the rat growth technique appears to be favored today (6). Gradual improvements and refinements—as well as recognition of the existence of provitamins A—have led to development of the growth method now included in the U. S. Pharmacopeia XI. This method requires that young rats weighing 40 to 50 grams (at an age not exceeding 28 days when placed on a vitamin A deficient ration) shall manifest symptoms characteristic of vitamin A deficiency within a period of 25 to 45 days. Rats properly depleted of vitamin A reserve are assembled in negative control groups receiving no supplement, reference groups receiving graded doses of the standard reference material, and assay groups receiving graded doses of the assay material. During the ensuing period of not less than 28 days, the test animals are fed daily doses of the proper supplements. The body weights of the animals are recorded at frequent intervals during and at the end of the assay period. From the average gains in body weight of rats in the assay and reference groups, dosages of assay and reference materials, and the vitamin A activity of the standard of reference, the vitamin A activity of the assay material is calculated.

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(1) 1913. J. Biol. Chem. 16, 423 and 255.

(2) 1928. J. Biol. Chem. 78, 671.

(3) 1931. J. Dairy Sci. 14, 229.

(4) 1927. J. Biol. Chem. 73, 153.

(5) 1938. J. Am. Med. Assoc. 111, 245.

(6) 1936. The Pharmacopeia of the United States,

Eleventh Decennial Revision, page 478.

(7) 1929. Ind. Eng. Chem. 21, 347.

1936. J. Am. Diet. Assoc. 12, 231.

1936. Mass. Agr. Expt. Sta. Bull. No. 338.

1938. Nutrition Abstracts and Reviews, 8, 281.

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*Laryngoscope, Feb. 1935
Vol. XLV, No. 2, 149-154*

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THE USE OF SULFAPYRIDINE in the treatment of pneumococcal pneumonias is now considered fundamental.

Authorities are agreed that sulfapyridine should be employed in all cases except in the instance of the rare individual in whom the administration of the drug produces toxic manifestations of sufficient importance to prohibit its use.

LONG and WOOD* reported a fatality rate of 7.2 per cent. in 139 adults treated at the Johns Hopkins Hospital. The authors attributed this low death rate to the use of sulfapyridine, antipneumococcal serum, and a combination of serum and sulfapyridine. Investigators are now uniformly reporting lower fatality rates than were before thought attainable.

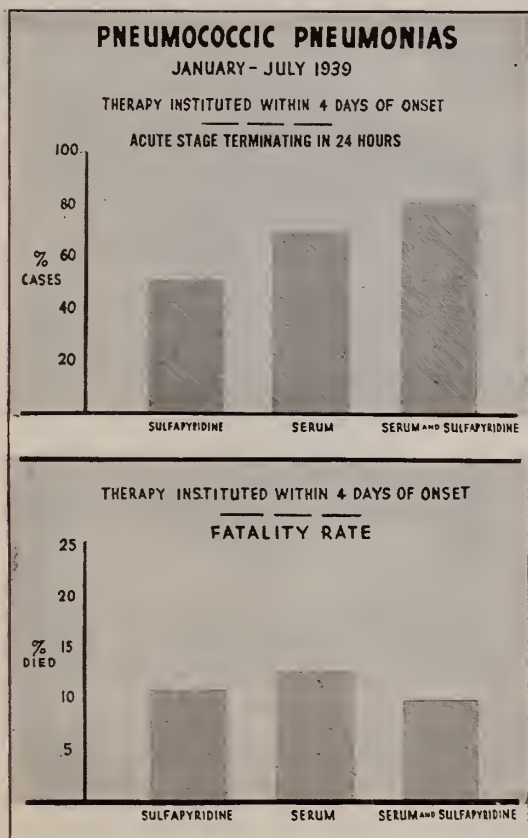
Toxic manifestations of the drug are similar to those described in the course of sulfanilamide therapy—central nervous system disturbances, drug rashes, drug fever, and disturbances in the red and white blood cells. Impairment of renal function is one of the most important complications.

Obtain sputum and blood cultures for bacteriologic diagnosis as a guide in treatment and aid in prognosis.

Administer sulfapyridine in adequate dosage to all cases.

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*LONG, PERRIN H. and WOOD, W. BARRY, JR.: Ann. Int. Med., Vol. 13, No. 3, Sept., 1939, Page 487.



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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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EFFECTIVE IN MINUTES



1:52 P. M.

Swollen turbinates and septum. Two inhalations from 'Benzedrine Inhaler.'



2:01 P. M.

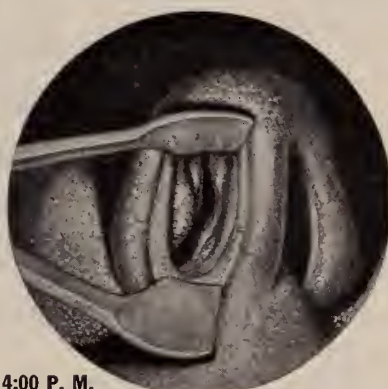
Maximum shrinkage. Inferior and middle turbinates and septum decongested.

LASTING FOR HOURS



3:15 P. M.

Inferior turbinate and septum still shrunk. Middle turbinate exposed.



4:00 P. M.

Both turbinates still contracted. Very slight return of turgescence.

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EDITORIAL

The Fall Clinical Conference

It is with sincere humbleness that I look back at the success of our Fall Clinical Conference. It demonstrated splendidly, to our conviction, how well equipped and organized our Hospitals are and how competent is the Medical Work that is carried on in them.

The occasion was also a splendid demonstration of the Unity of the Medical Profession at large within our State. There is only one aim: To do the best in the interests of our beloved profession and humanity. My congratulations and heartfelt thanks to all members of our Society.

This introduction to the December *Bulletin* of the Hudson County Medical Society by its President, Dr. James F. Norton, expresses the sentiments of every physician who attended the Second State Fall Clinical Conference, of which the Hudson County Medical Society was the host. This opinion is confirmed by the report of Dr. Samuel A. Cosgrove, general chairman of the Conference, which is printed on page 727 of this Journal. His report is modest and brief, and yet touches upon every phase of the organization and management of the Conference.

It is remarkable that 40 per cent of the members of the Hudson County Medical Society participated in the lectures and demonstrations. Every member of this group deserves more than the mention of his name in the list of participants, which is printed on page 729. But to this list of participants there should be added the unnamed assistants whose efficient services were essential in carrying out the programs.

There was also that group of members who rendered essential service on reception committees, and were always ready to answer inquiries of visiting physicians, and to guide them to the meeting places.

Another group that deserves recognition is the members of the Woman's Auxiliary who served as a reception committee and made the visiting doctors feel at home. They demonstrated the helpful service which the Auxiliary is designed to render to the Medical Society.

A fitting climax of the Conference was the social dinner held on Friday evening in the Carteret Club, when Dr. Morris Fishbein, Editor of the Journal of the A. M. A., reviewed the relations of the medical profession to the proposed medical activities of the Federal Government.

The outstanding success of the two Fall Clinical Conferences justifies their repetition as an annual feature of The Medical Society of New Jersey.

Reporters of County Societies

The first formal recognition of *Administrative Medicine* in New Jersey was the establishment of the *Standing Committee* by The Medical Society of New Jersey under its by-laws adopted on May 9, 1820 (Transactions, Vol. 1, page 188). The functions of the committee were:

1. The investigation of prevalent diseases, especially their relations to climate and topography.
2. The correction of irregularities in the practice of medicine.
3. The establishment of standards of practice in order to promote "The respectability of the Medical Profession, and the well-being of the citizens".

The Standing Committee gradually evolved into the present system of the Board of Trustees, and the Welfare Committee with its score of sub-committees.

From the time of its establishment of the Standing Committee 119 years ago, an essential part of the organization of The Medical Society of New Jersey has been its system of Reporters for the county societies. Today the essential duty of the reporter of a county society is to report the activities of his county society so that it may be published in The Journal of the State Society. How well the reporters have performed their duties is shown by the fact that their reports fill an average of ten pages in each issue of The Journal. Since the county societies have expanded their fields of activity to include practically every activity of the State Society, their monthly reports are of constantly increasing value. The record of every meeting of every county society is of interest to every member of The Medical Society of New Jersey, for the sum of their activities are the measure of the efficiency of the State Society.

The School of the Medical Society

Every physician in New Jersey is instructed and trained in two schools:

First, his *compulsory* training in the medical school and in the hospital internship. This instruction is ninety-five per cent in *scientific* medicine, with scant reference to the *administrative* phase of medicine.

Second, his *voluntary* training in *administrative* medicine which he gets in the school of the county medical society and the State Society.

THE SCHOOL OF THE COUNTY SOCIETY

The County Medical Society is essentially a *school of research* along three lines:

1. Making surveys of local medical needs.
2. Planning to supply those needs.
3. Instructing and inspiring local officials and welfare organizations to do their part in supplying local medical needs.

THE FACULTY OF THE SCHOOL OF THE COUNTY SOCIETY

The faculty of the school of the county society consists of its officers, and its committee chairmen.

The assistants to the faculty are the members of the several committees. From one-quarter to one-third of the members of the county societies are enrolled in the faculties, and as active research workers of the State and the county societies serving on committees. Count them and prove the truth of this statement.

The importance of the schools of the State and county medical societies is shown by the use of the term *faculty* to denote the members of the medical profession in the call to form The Medical Society of New Jersey in 1766. The term is repeated in the record of the meeting of May 1, 1776, and again on May 12,

1818. The name of the Medical Society of the State of Maryland is still "The Medical and Chirurgical Faculty of Maryland".

TEXT-BOOKS

The *County Bulletins* and the *State Journal* are the essential text-books from which *all the members* of the County Society may learn of the activities of the Society whether or not they attend the meetings and hear the *verbal* reports.

DISCUSSIONS AND DECISIONS

The services of the Editors of County Society Bulletins, and the Reporters of the State Journal, are both honorable and essential. The subjects with which they deal may be considered under two headings:

1. Discussions.
2. Decisions.

Discussions and progress reports are always important items of current interest, for they reveal what the members are thinking about, even if definite decisions are not reached.

The annual index of the State Journal lists every subject of discussion that is contained in

the monthly reports of the county reporters, even if the item is only two lines in length.

GRADES AND ADVANCEMENTS

There is a system of grading in the school of the Medical Society, in which the physician may advance step by step:

First, as a member of a committee of a county society.

Second, as a chairman of a committee.

Third, as an administrative officer.

Fourth, as a member of a committee of the State Society.

Fifth, as chairman of a committee of the State Society.

Sixth, as an administrative officer of the State Society.

The members are expected to advance from grade to grade according to their native ability and their experience. There is always an opportunity for a member to advance to a higher position of research and teaching, thereby enlarging his own field of usefulness, and also giving another man an opportunity to perform an honored service on the faculty of the school of the medical society.

Illustrations in The Journal

It has been the policy of the Publication Committee to encourage the use of pictures in illustrating articles in The Journal. The Chinese have a truthful saying that "One picture is worth a thousand words". It is also true that some pictures need a thousand words in order to explain their meaning. It is further true that some essential ideas in surgery and medicine cannot be imparted by the use of both words and pictures, but require the reader to have a background of knowledge and experience for their reception and interpretation.

DETAILS

The most effective picture is one which conveys a single idea. Too many details in a picture is like an excess of words or sentences in a paragraph, for they are likely to obscure a thought rather than clarify it. If an illustration contains many unrelated details, it is

always proper to indicate the essential ones by the use of arrows.

The Editor is the guinea pig in whom an idea is first inoculated. If the author's idea "Takes" with the Editor, it is likely to impress the reader also. The Editor must edit the illustrations as well as the text of an article.

A diagram is a picture reduced to its simplest terms, and is effective because it omits all distracting details. Many a picture is vastly improved when it is redrawn as a diagram with the fewest possible lines.

A CENTRAL IDEA

It is a fundamental rule in illustrations for a medical article that the particular point to be illustrated shall occupy the greater part of the area of the picture, and at times that two small pictures shall be made instead of a single large one. For example, a lesion of the lip may be

shown most effectively by a life-size picture showing the affected part as it would appear to the naked eye from a distance of two feet; and a second one as it would appear in a close-up or under an ordinary magnifying glass.

When a large picture is submitted, it frequently occurs that only a part of it is reproduced in natural size; and then a still smaller part is enlarged for a second cut.

It is the rule, rather than the exception, that the editor shall consult the author regarding the make-up of his illustrations, such as the area to be included and the size of the completed picture. The author knows better than the editor what he wishes to show.

PORTRAITS

Believe it or not, photographs of faces on the printed page usually show best when they are reduced to an inch, or an inch and a half in size. We usually judge the features of a person when he is about fifteen feet from the observer. A good photograph of his face an inch square subtends the same angle in the eye that the natural face does from a distance of fifteen feet. Moreover, in the smaller picture, the eye "Takes in" all the features in a single glance; whereas in the life-sized picture the eye wanders from point to point, and sees a single feature at a time; and so the reader is unduly impressed by that feature, such as the beard, or the crook of the nose, rather than the entire "ensemble" of the face.

As a demonstration of these principles, turn to the small photographs of the officers and chairmen of committees, and those of the guest

speakers, which appear in the Journal of May, 1939.

COST OF CUTS

The price of cuts depends on many elements besides their mere size. To make a cut an inch square requires as much time of an expert workman, and the use of as much expensive materials and machinery as one filling half a page. But if the originals are all of the same size and quality, they may be reproduced on a large plate by a single operation, and the cost of each may be reduced. It is a fair estimate that the cost of making a single plate two and a half inches square is three or four dollars, while the cost of a full page plate will be about eight dollars.

It is the custom of this Journal that the authors of scientific papers shall pay the cost of the plates for the illustrations, but the plates belong to the author for his use in reprints or in other articles which he may write. Each author is informed what the probable cost of the plates will be before they are made. Also advertisers always pay for the plates used in their announcements. In the case of cuts used in descriptions of Medical Society activities, the cost is borne by the Journal, and is charged against a budget provided for that purpose.

It is the custom of the Editor to consult the engraver concerning every cut that is made. The engraver thereby assumes the responsibility of delivering a perfect cut, even though he may have to do some experimenting to produce one that is satisfactory. Almost the only difficulty that arises is that of reproducing x-ray pictures; but that is a subject requiring a separate article.

Volume XXXVI of The Journal

With this number the *Journal* completes its thirty-sixth volume. The volume is gratifying evidence of the coöperation that is developing in the triad of groups that are vitally concerned with the distribution of medical services:

1. The sick and their families.
2. The medical profession.
3. The community.

In September, 1904, when the first number

of the Journal was issued, the medical profession received little coöperation from the community; but now the government is tending toward the assumption of control over the physicians. New Jersey has gone further than any other State in developing a mutual understanding among the three groups, with the *Medical Society* acting as the trusted adviser of the *Community*.

ORIGINAL ARTICLES

TRIBUTE TO DR. EDWARD J. ILL, "FIRST PRESIDENT, BENEFactor AND TRUSTEE OF THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY," ON THE ESTABLISHMENT OF "THE EDWARD J. ILL AWARD"

By WELLS P. EAGLETON, M.D., Newark, N. J.

Address delivered at a Stated Meeting of the Academy of Medicine of Northern New Jersey, held in honor of Dr. E. J. Ill's Eighty-fifth Birthday, on Tuesday, May 23, 1939. (See Journal, August, 1939, p. 517.)

When at a Council meeting of the Academy of Medicine of Northern New Jersey, its President, Dr. Henry C. Barkhorn, suggested the establishment of the "Edward J. Ill Award," it was greeted with a unanimity that in itself was an expression of the respect in which Dr. Ill is held by his confrères of this, a later day than that in which he was in active practice among the doctors of Northern New Jersey.

The designation of the award is not because Dr. Ill is eighty-five years old; it is not because he is still mentally alert although long since past the "peradventure four score years"; nor is it only because of his scientific achievements as a physician; but it is mainly for that which he has contributed toward increasing the respect in which the medical profession is held by the public of New Jersey. This has been of lasting value to his fellow physicians.

Although Dr. Ill was the first to bring anti-septic surgery to Newark, this was but an accident of the period of his advent into practice. However, it was fortunate for us that he was graduated in medicine in 1875, when *antiseptic* surgery was young; and that he lived through its successor, *aseptic* surgery. For as the late Dr. James T. Wrightson often said, "Having seen them all work, I am of the opinion that no surgeon operating before the days of Listerism ever was able to acquire a really good aseptic technic."

This was no reflection on the work of the surgical heads of Newark's hospitals at that time—chief of whom were Dr. William O'Gorman (1824-1887) of St. Michael's Hospital,

and the elder Dr. Dougherty (Alexander N., 1822-1882), who had had a very large experience during the Civil War, or of Dr. Jeremiah A. Cross (1827-1881), or of Dr. Abraham Coles (1813-1891), a monument to whom is in one of our parks. For these men were trained, and thus continued to think, in an age that ended suddenly—ended when Pasteur (1822-1895) drew the first picture of microorganisms causing child-bed fever, on the blackboard before a meeting of French physicians, none of whom had ever dreamed that microorganisms even existed, let alone were the cause of infection. In the same way we of today have witnessed the "End of Economic Man";¹ for in America, as in Russia, and now in Germany and Italy, the worship by youth of economic success² as the highest aim of life, is dead—dead as Caesar—although we elders, trained in another age, appreciated it but little.

Nor would I emphasize Dr. Ill's contributions to gynecology, or that his operation for repairing the perineum, in 1896,³ was a distinct improvement in gynecological technic.⁴

Gynecological surgery and its sister specialty, abdominal surgery, were America's major additions to the medical knowledge of the eighteenth and nineteenth centuries, beginning with the work of Ephraim McDowell⁵ (1771-1830),

1. Drucker, Peter F.: The End of Economic Man. John Day Co., 1939.

2. Kolnai, Aurel: The War Against the West. Viking Press, 1938.

3. Ill, E. J.: (a) A Contribution to the Surgery of the Female Perineum, (Nov. 16) 1896; (b) Secondary Repair of Complete Perineal Lacerations; Its Technic and Results, (Sept. 20) 1910.

4. Ward, George Gray: Edward J. Ill, the Versatile Man. J. Med. Soc. New Jersey, 1933.

5. Cutler, Elliott C.: Ephraim McDowell, the Surgeon. New England J. Med., 202:276-278 (Feb. 6) 1930.

who performed the first successful abdominal section in a Kentucky frontier town in 1809. McDowell was stimulated to the performance of undreamed-of surgical operations in Edinburgh, chiefly by John Bell (1763-1820), who gave independent courses, being kept outside the University because of his ability, straightforwardness, and criticism of Edinburgh's professors of surgery. How familiar it all sounds—professional jealousy of the unconventional but on-coming man!

McDowell's brilliant surgical contributions⁶ were continued through Dudley (Benjamin Winslow, 1785-1870) of Cincinnati, Gross (Samuel D., 1805-1884) of Louisville, Agnew (David Hayes, 1818-1892) of Philadelphia, and Marion Sims (1813-1883) of New York, Battey (R., 1828-1895) of Georgia, who performed the first ovariectomy for painful menstruation in 1872—all born in that creative air of the American frontier—down to Dr. Ill's own teacher, the elegant T. Gaillard Thomas (1831-1903). Dr. Ill was stimulated by the surgical skill of that descendant of the Irish patriot and martyr, Robert Emmett, namely, Dr. Thomas Addis Emmett (1828-1919) of New York, and by the work of Skene (Alexander J. C., 1838-1900) of Brooklyn, and his contemporary, Kelly (Howard A., 1858-) of Baltimore.

Dr. Ill has always contended that the only guide for a doctor's conduct should be, "What is for the best interest of the patient?" This he has repeated over and over again. And while his habit of refusing permission to his younger associates to attempt surgical procedures, even long after they thought that they were qualified to perform them, met with criticism, it was because he believed that he was acting in the best interest of the patient by such a course.

For we doctors of this, a succeeding generation, must realize that Dr. Ill was trained in the continental tradition of absolute subservience of all assistants to the Chief of Service—a custom which became outmoded during his lifetime by the progressive improvements in surgical technic. Today any such restriction is

largely discarded—too much so, I fear—when a surgeon, no matter how incompletely trained, can find a hospital tempted to help shoulder the responsibility of his operative acts, because it is largely sustained by moneys from patients of physicians having "courtesy privileges". And despite the work of the American College of Surgeons, there still are doctors on the staff of some hospitals chiefly because of the number of private patients they send to them.

In the fall of 1876, Dr. Ill returned from Europe, where he had studied under Waldeyer and Von Recklinghausser in Strasbourg, Meiner in Vienna, and Hegar, Czerney and Kussmaull at Freiburg.⁷ From this time on, for over fifty years, his name has been associated with every activity for the advancement of the medical profession in New Jersey: chiefly (1) in helping to enact medical legislation for the protection of the public and of the profession; (2) as one of the founders of the Academy of Medicine of Northern New Jersey; and (3) as a member of the first commission for "Sterilization of the Mentally Unfit".

Dr. Ill has served in public office, having been elected a School Commissioner of the City of Newark in 1879, in which capacity he had enacted the law preventing children who had had scarlet fever from returning to school unless they had a doctor's certificate. And as a physician he proudly wrote, "No doctor charged a fee for issuing such a certificate." He also was elected Trustee of the Newark City Home for Boys, serving from 1881 to 1895; and has been a State Director of the Prudential Insurance Company, representing the policy-holders on the Board of Directors, since 1909.

But it is not for these alone that tribute is paid today to Dr. E. J. Ill by the Academy.

For Northern New Jersey has produced many good physicians who have rendered conspicuous public services; and there are at least five who, in my opinion, have contributed something of lasting value to each and every doctor, and through them to the community of this State as a whole. They are:

6. McDowell reported his first three successful abdominal sections in 1817 in the "Electric Repertory and Analytical Review".

7. Ill, Edward J.: *The Story of My Family*. Soney & Sage Co., Newark, N. J. 1935.

1. Dr. Henry Coit (1854-1917), who conceived the principles of "Certified Milk"; whereby milk, in large amounts, can be transferred uncontaminated from the cow's udder into sterilized bottle containers, where it remains sweet for a long time. Dr. Coit insisted that, as the technical procedures were applications of surgical Listerism, they would be properly carried out only under the supervision of a nonprofit-making medical commission animated by the ideals of the medical profession. Only thus, he contended, would the milk be properly certified to.

For all his years of work, Dr. Coit, following the tenets of our craft, never asked for, nor received, any compensation whatsoever, although "Certified Milk" has revolutionized the distribution of pure milk the world over.⁸

2. Dr. James T. Wrightson (1853-1927), who was chiefly responsible for the enactment, in 1890, of New Jersey's first Medical Practice Act, which created a State Board of Medical Examiners,⁹ despite the active opposition of the medical profession, because the law recognized both the homeopaths and the eclectics.

This law, with its successive amendments, enacted to meet the changing conditions of the times,¹⁰ in my opinion, is today the best medical regulatory act in our nation. For it allows the osteopaths, and now the chiropractors, legally to practice medicine and surgery within New Jersey when they are qualified, and have passed the Board's examination, thus showing the possession of an education sufficient to protect the public against ignorance of demonstrated medical and scientific truths. The entire Medical Practice Act of New Jersey is founded on the profession's slogan of 1922, "Educational Qualifications for All".¹¹

3. Dr. Peter Hulett¹² (1846-1906), who was responsible for the founding of the Newark City Hospital in 1882, and its continued

existence. The Newark City Hospital, in my opinion, has done more for the dissemination of medical knowledge than any other hospital in this State.

During the infancy of the hospital, when the annual appropriation had been fully expended two months before the expiration of its budgeted time, and when to contract indebtedness would have made the "Committee appointed by the Mayor" which operated it, liable to imprisonment, Dr. Hulett announced that he personally would provide sufficient moneys to pay for food, salaries, and equipment. He thus kept in operation a municipal institution, which, once closed, probably would never have been reopened, because the semicharitable private hospitals saw their appropriations from the City endangered, as well as the loss of interesting cases formerly sent to them, and paid for by the City.

4. Dr. Charles J. Kipp (1838-1911), who founded, in 1880, the Newark (Charitable) Eye and Ear Infirmary. He placed medical men in control, as he realized—having had a large hospital experience during the Civil War—that only trained medical men are qualified to formulate the policies of a hospital.

The Infirmary has continuously furnished "gratuitous care to the indigent blind and deaf," as called for in its charter. In spite of changed economic conditions it is one of Newark's three semiprivate hospitals that have not had to resort to a "special public drive". It has not become an institution chiefly for paying patients. The attitude of the Infirmary towards the medical profession has always been that opportunity for acquiring knowledge will be given any physician who (a) wants to work in any of its special branches of medicine, (b) is a gentleman in thought, as well as in deed, and (c) is a member of organized medicine.

5. Dr. Edward J. Ill (1854-) for leadership in upholding, in 1908, the essentially ethical and altruistic basis of our profession. For he then established the principle that a physician's position on a hospital staff must depend entirely upon the care and skill that he renders the patients assigned to him, and not on the financial support that the doctor may bring to the hospital.

8. Eagleton, W. P.: A Doctor's Confession of Faith: I Speak of the Children of Hippocrates, of the Cult of Aesculapius. An address at the 33d Annual Banquet of the Washington Med. & Surg. Sec., Mayflower Hotel, Washington, D. C., May 5, 1930.

9. Eagleton, W. P.: Some of the Needs of the Medical Profession in Essex County. J. Med. Soc. of New Jersey, (May) 1909.

10. Amendments or Supplements of 1894, 1903, 1913, 1915, 1922, 1935 and now of 1939.

11. Eagleton, W. P.: History of the Welfare Committee of The Medical Society of New Jersey, in preparation.

12. A Remembrance of Peter Van Pelt Hewlett, M.D., by Marie E. Rutherford (published privately by Baker Printing Co.).

Dr. Edward J. Ill was born of a father whose liberalism forced him to flee from Germany in 1849, under sentence of "high treason," into Switzerland.⁷ He later emigrated to America in 1850, and located in that part of Newark which, because of its unpaved roads and rough lots, was known as "Stump Town" on "Dutch Hill".

When the Asiatic Cholera Epidemic attacked the metropolitan area in 1854, Dr. Carl Fredolin Ill (1821-1885) treated, without compensation, large numbers of patients, saying later, "the people were swept away by hundreds," "being absolutely poor and much distracted".⁷ He was one of those political refugee intellectuals and artisans of the higher class of German birth—Newark forming one of their chief centres—who added its share to the American nationalism of the last century. Their chief contribution was a widening of our Puritan culture, which, in spite of its stalwart understanding of Anglo-Saxon constitutional liberty, was narrow in many respects.

Among our greatest weaknesses was American adulation of financial success, no matter by what means obtained. For amid the expansion of our West, immediately following the Civil War, there appeared a worship of "Big Business," with its "Captains of Industry," which culminated in "A Chicken in Every Pot" and "Two Cars in Every Garage". False gods!—now, thank God, discredited! found wanting! having failed to satisfy that upward longing of the soul of our youth—which is the true strength of our nation.

And during this period, all over our land, there were to be seen hospitals, medical schools, cultural and educational institutions with buildings! buildings! buildings! plastered with the names of men who had done nothing but accumulate wealth.

And here in New Jersey, all must commend there being a "Mercer Hospital," located in Trenton where that brilliant physician, Dr. Hugh Mercer (about 1721-1777), administrator, soldier, and the friend of Washington, rendered such valuable service to our nation and who was mortally wounded on the adjacent field at Princeton January 3, 1777. But that culminating piece of political impertinence—

the Margaret Hague Maternity Hospital! And it is sad to relate that there was no united voice of protest from the medical profession of New Jersey, on its opening, so dominant is the successful man, be he but a political boss.

For public hospitals, schools, and all cultural institutions, surely when supported by public funds, should be named only for those whose spiritual or public services have added an "upward reach" to higher and better things, such as the "Babies' and Coit Memorial Hospital".

The year 1909 was a time when Newark's hospitals (founded by physicians assisted by public-spirited groups) had begun to pass into the hands of non-medical men; this largely because of the increased costs necessitated by the technical advances in medical science. These finance-minded groups attempted to make our hospitals self-supporting, largely from the revenues of patients, while formally they always had been benevolent institutions supported by private contributions. The directors thus came to regard the hospital's private patients as of prime importance.

When Dr. Ill and Dr. Charles J. Kipp, the two most influential members of the medical profession in New Jersey, publicly resigned from the staff of the Newark German Hospital as a protest against the discharge of three doctors by a lay Board of Directors, because the physicians had not provided a sufficient number of paying patients; when Dr. Ill¹³ announced: "I felt that an indignity had been offered the profession as a whole, and I felt the indignity so much because I was a consultant at the hospital"; when he stated in the public press, and before local¹⁴ and county medical societies,¹⁵ and wrote in the *Journal of The Medical Society of New Jersey*¹⁶ so that his protest reached everyone in our State: "Is it right that the honest practitioners whose clientele is among the poor should be thus treated?" "Are the directors of the hospitals to judge us by the financial aid that

13. Dr. E. J. Ill on the German Hospital Staff of Newark: "Hospital Turns Down Doctors," *Newark Evening News*, (Jan. 28) 1909. "Drs. Ill and Kipp Opposed to Dropping Physicians," *Newark Evening News*, (Jan. 30) 1909.

14. Ill, E. J.: "Insulting the Profession to Which Its Success Is Largely Due," read before the Practitioners' Club of Newark.

15. Essex County Medical Society, (Feb. 16) 1909, and Somerset Medical Society, (Feb. 11) 1909.

16. Editorial—"Hospital Control in Its Relation to the Staff," *J. Med. Soc. New Jersey*, (Mar.) 1909.

we give them, or by the care and attention we give to those in the wards?" "Do we ever ask whether patients pay for their beds, or do we care to know whether they are the poorest of the poor?"—then Dr. Ill contributed mightily to that true dignity that has always dominated the best of our profession.

The Drs. Ill and Kipp incident of 1908 was but one of three movements that have occurred, during my lifetime, in which high-minded and courageous leadership has fortified the ethical outlook of the profession of New Jersey.

The first occurred in 1897, when a group of young doctors of Newark—the Physicians' Club—publicly dropped one of its most prominent members, because of his refusal to stop exploitation of his work in the public press by the report of dramatic cases diagnosed by x-ray, which was then new; he possessing the only x-ray outfit in New Jersey. The doctors of New Jersey thus early put their stamp of disapproval on that type of commercial self-exploitation, which has tended to bring the medical profession in disrepute.

For in recent years commercial self-exploitation has not only passed unproved by those high in the authority of organized medicine, but has been actually encouraged,¹⁷ and has even been endorsed by a presiding officer of the House of Delegates of the American Medical Association, as a "splendid work". This would not be so shocking had the misleading advertising practices not been conducted under the pretense of conformity to medical ethics, which latter by nonenforcement have gradually become misunderstood and distorted in some communities. For true medical ethics are the every-day application of spiritual precepts—not rules to obtain material and financial advantages.

The most recent incident of importance to the whole profession was in 1931, when the Essex County Medical Society, outraged by the unjust interference of a lay board in the medical management of one of our hospitals, formulated and enforced the principles that—

17. Action of Committee of the Whole on Resolution Relative to Editor's Writings, Minutes of the 89th Annual Session of the American Medical Association, held at San Francisco, Executive Session, Tuesday, June 14th, J. A. M. A., 111:52, (July 2) 1938.

1. There be adequate representation of the Medical Staff on all hospital Boards of Trustees;

2. That "there should be no change in the medical policy of a hospital without proper consultation with the Staff";¹⁸

3. That "no physician who has efficiently and faithfully and loyally served on a hospital staff should be removed, or demoted without proper consultation with representative members of the Staff"; and

4. That "the medical profession should present a united front in support of the foregoing general principles, which are in the interest of the hospitals, which the profession dearly loves, and of the patients whom they serve".

These three movements, all of them having a non-material, ethical basis, were opposed by a small minority of doctors in our midst; this, because they saw prominent physicians of other states reaping rich rewards in practice through blatant, although disguised advertising; or by lending assistance to non-medical interests that aimed to weaken the influence of the medical profession.

The chief opposition was because of a fear of legal proceedings; for on all three occasions threats to invoke the law against the leaders of the movement were made. However, all three movements reflected the true character of the doctors of New Jersey, and were endorsed by the whole profession.

During all three "crises," when the profession was marshalling its forces to act, Dr. E. J. Ill played a helpful part.

And today, we, the doctors of New Jersey, are the beneficiaries, for the respect in which the profession and the individual physician are held is of the highest. And The Medical Society of New Jersey is one of the few State Medical Societies with great political influence, its opinions being given an attentive hear-

18. Note: The Essex County Medical Society adopted the following resolutions:

"1. The Essex County Medical Society extend congratulations to the members of the Medical Staff of the Hospital and Home for Crippled Children for their stand on behalf of management of the medical affairs of a hospital by its Medical Staff.

"2. That they condemn practices of a lay board of trustees which ignore the medical staff in medical management.

"3. That the Medical Staff concerned may be assured of the support of the Essex County Medical Society in maintenance of these principles."

Bulletin Essex County Medical Society, Newark, Dec., 1931, No. 4.

ing by our United States Senators and Congressmen, and its representatives consulted by New Jersey's State officials in all matters relating to the public health. This is shown by the appointment by Governor Moore of a council to ascertain the health needs of New Jersey,¹⁹ containing a large representation of doctors, all of whom were suggested by The State Medical Society—the only intelligent way to approach such an important and many-sided problem.

For the respect, or suspicion, in which Medicine is held in any community is a true reflection of the public's opinion concerning what attitude organized medicine assumes toward "the furnishing of adequate medical care," which has become the great health problem of the day, of interest to all public-spirited people. In those states where Medicine fearlessly shoulders its responsibilities, it is respected; when it hedges and equivocates, it is suspected; and when material advantages are held up as the goal of Medicine, then it is justly accused of unworthy motives.

For we doctors in New Jersey still believe in those ethical principles and humanitarian purposes formulated in 1766 by The New Jersey Medical Society, the first State Medical Society in the Western Hemisphere: (1) "Mutual improvement"—spiritual and intellectual betterment"; (2) "advancement of the profession"—not exploitation of the individual or of the profession; (3) "promotion of the public good".²⁰

And we still believe that all State Medical Societies and the national body of American organized medicine should inscribe on their banners, as our founders did: "We have separated ourselves to an office of benevolence and charity."

We doctors (the Medical Society) of New Jersey have long since viewed with alarm the flagrant commercialism and materialism of the bureaucracy within our national organization

itself. In May, 1938, I publicly warned that "unless we of organized medicine put a stop to certain abuses in no uncertain terms, Medicine is doomed. It is already in disrepute because of these abuses."²¹ I further said: "The reprisals that have emanated from headquarters of the A. M. A. to any state that had the audacity even to criticize its policies, really are unbelievable in a scientific organization."²²

And now that the national body of organized medicine in America is attacked, when, for "the first time, its leadership is discredited, its motives questioned and its methods suspected,"²³ The Medical Society of New Jersey is insisting, through its representatives in the House of Delegates of the American Medical Association, that we doctors again assume that leadership which organized medicine abandoned by default. For we think it is the duty of the American Medical Association to formulate plans so that all our people may have adequate medical care. And at the same time New Jersey is sincerely trying to assist in the restoration of that respect for the medical profession in which the physicians of the land have always been held.

It is for Dr. Ill's part in upholding our ethical standards and advancing surgical practice—services rendered to the whole medical profession of New Jersey—as well as for the major part that he played in the continued development of the Academy of Medicine of Northern New Jersey, that the Academy's Council resolved: "There shall be established from the general funds of the Academy the Dr. Edward J. Ill Award. The Award shall be given, at such times as the Council deems wise, to that doctor from Northern New Jersey who merits it for his extraordinary service as a physician and as a citizen."

21. New York Times, May 20, 1938: "Jersey Physicians Denounce Fishbein. Vote to Ask A. M. A. Convention to Restrict Writings . . . 'Abuses' Deplored. 'Organized Medicine Doomed Unless They Are Stopped'."

22. Report of Reference Committee IV, Trans. 172nd Annual Meet. Medical Soc. New Jersey, Atlantic City, May 19, 1938. Suppl. J. Med. Soc. New Jersey, Aug., 1938, page 58.

23. Eagleton, W. P.: "Thou Shalt Not Remove . . . Landmark(s) Which They of Old Time Have Set in Thine Inheritance." A New Jersey Doctor's and his Wife's 1939 Salutation to His Fellow Practitioners and Their Wives. Based on the Address "The Medical Society of New Jersey in Relation to Medical Economics and Its Efforts to Have the American Medical Association Formulate a National Health Program," New Jersey, on Nov. 16, 1938.

19. "The New Jersey Health and Welfare Conference" of 1939.

20. "The Instruments of Association and Constitution of the New Jersey Medical Society," adopted at New Brunswick in the Province of East New Jersey on July 23, 1766. Article 5 in Transactions, Vol. 1, 1766-1858, page 4.

WHY CANCER SHOULD BE OF INTEREST TO THE GENERAL PRACTITIONER

By W. G. HERRMAN, M.D., Asbury Park, N. J.

Delivered before Monmouth County Medical Society, January 25, 1939; and the Atlantic County Medical Society, March 10, 1939, as Chairman of the Sub-Committee on Cancer of The Medical Society of New Jersey.

In 1900 the expectancy of life was some forty years. Today, one who passes the diseases of infancy and childhood may look forward to a life expectancy of some sixty-four years. A number of years ago, one in twenty of those alive was over sixty years of age. Today it is one in twelve; and it is predicted that within a comparatively short number of years it will be in a ratio of one to six. A few short years ago we had continued complaints of the overcrowding of our schools, especially the lower grades. Now we are beginning to hear reports from here and there of empty seats in our school rooms. Already business counsellor services are advising their clients that the profits of the future will come to those who invest in goods to be sold to the aged rather than those that cater to the infant and child. What does this mean to us as physicians, both from an economic standpoint, and from the public health angle? It is obvious that we must begin to appreciate the increasing importance of *geriatrics*, in contra-distinction to *pediatrics*, and that the so-called degenerative diseases will play a larger and larger part in the practice of medicine if this trend in age ratio of the population continues, as there seems every evidence that it will.

In 1905 the principal causes of death in our State were as follows, in order of their importance: Tuberculosis, pneumonia, heart disease, kidney disease, apoplexy, and cancer. In 1935 the order was considerably changed. Tuberculosis was now sixth instead of first, while heart disease had become the first cause of death.

We are concerned tonight not with the discussion of all of the diseases of middle and old age, but of this one disease, *cancer*, which now ranks second in importance among those diseases which are afflicting our population in the higher age brackets. In 1920 the rate per 100,000 in the State of New Jersey for cancer was some 88. It has steadily risen for the last

fifteen years and more, to 125 per 100,000; latest figures show it to be over 130. A bulletin issued by the Department of Commerce on vital statistics for July, 1938, shows that the State of New Jersey had a total number of deaths from cancer of 5,389. Cancer statisticians tell us that we must multiply the cancer deaths by approximately four, in order to estimate the number of cancer cases in existence at any one time. This would give the State of New Jersey a total number of approximately 21,000 cancer cases on any given date. In Monmouth County the death rate has risen from 108.4 in 1920, to 156.6. This is not, at the present time, the highest rate in the State of New Jersey, there being five counties with a higher rate than my own, while there are two others that are practically equal; but we do have, and have had, a higher rate in Monmouth County than in the State as a whole. Monmouth County has approximately three per cent of the population of the State, and it should have three per cent of the 21,000 cancer cases of the State,—or 630. With 120 practicing physicians, each doctor should have about five cancer cases in his own practice. It is, therefore, eminently fitting that we, as physicians, should give more than passing thought to those things which may tend to check the rising tide of cancer.

I said a moment ago that our interest should be aroused in this subject from both the *economic* and the *public health* standpoints. I say economic first, because we should have an honest and healthy personal interest in the subject. A man does not enter the practice of medicine primarily to make money, but certainly the majority of men who enter the profession expect to make their living from the practice of medicine. There are those who take up the study of medicine because of a deep interest in research, and these men almost invariably find their way into our research foundations and teaching institutions; and it is to the glory

of medicine that there are many such. There are others who enter the profession for what good they can do, such as the clergy,—and these will often be found in the missionary field, or practicing medicine in connection with charitable foundations. All honor to them, but the majority of the men in the profession enter it with mixed emotions. They have a living to make, they have hopes of raising and educating a family, and at the same time they are interested in the scientific aspects or else they would not be members of the profession. All of us have been brought up with the idea that, in the course of making a living, we may be of service not only to those who support us, but to those who need our help and can make no return; but there is this economic angle to the practice of medicine, and there is nothing to be ashamed of in stating it. If more and more of those who are our private patients are reaching the years when they will be afflicted with such diseases as cancer, it behooves us to be prepared to take care of them. If the patients so afflicted can be preserved for a number of years, they will continue to be our patients. If they receive treatment which they know saves their life, they should be grateful to those who recognize the need for proper treatment and to those who provide it. Furthermore, the preservation of a head of a household and his continuance as an economic unit will many times preserve to the practicing physician a family who can contribute to his income; while if this head of the family is taken away, the rest may be unable to pay for services which they themselves will need; so that there is a very healthy personal and selfish reason why the man in general practice should become exceedingly cancer-minded. From the public health standpoint it has always been our principle not only to make an effort to cure disease where we find it, if possible, but to help eradicate its source, and prevent the onset of diseases in those of our patients who may be subject to them.

THE GENERAL PRACTITIONER AND CANCER

The general practitioner will say, "Well, what part can I play in the treatment of cancer? Once the diagnosis is made, I am con-

tinually told that the only hope for cure or alleviation is in the hands of the surgeon or radiologist, or both. Today that is true. There are no results of any proven value in the treatment of cancer other than those to be obtained by surgery, x-ray radiation, and radium; and any particular case may need one alone, or a combination of all three. The time may come, however, when the treatment will be largely medical in the form of administration of biological, or chemical preparations. However, until the time comes when the treatment will be almost entirely in the hands of a medical man, there still is a great deal he can do. In fact, the general practitioner is the first line of defense against the inroads of this disease; but to be of any help in the fight, the general practitioner must become *cancer-minded*, which in many cases he distinctly is not.

In the first place, the general practitioner must recognize the conditions which exist in his patient prior to the formation of cancer, and which may lead to it. Sir Lenthal Cheatele states that cancer in the breast of a woman appearing at the age of forty-seven had its forerunner in that breast at the age of twenty-seven. This is merely a dramatic way of drawing attention to the *pre-cancerous* lesion. This pre-cancerous lesion will be seen first by the man in general practice; and if he eradicates it himself, or advises the eradication of it, he has warded off the development of cancer in that particular patient for many years, or perhaps a lifetime.

In the second place, the family doctor must be continuously on guard so as to recognize the first onset of the disease itself. Many, many times a patient goes to his family physician feeling that perhaps he has cancer. His physician fails to recognize the symptoms, and may "pooh pooh" it, or laugh it off. I have in mind a close personal friend who was treated for "Nervous prostration" in beginning menopause, without a vaginal examination being made, and when I first saw her and made such an examination, there was already a fairly well advanced cancer of the cervix present.

In the third place, nearly all of our cancer sufferers are in middle life, or older. They will, therefore, present with that cancer other

degenerative diseases affecting the cardio-vascular system, the kidneys, the liver, the pancreas, etc. Many times before either the surgeon or radiologist treats the actual cancer, the patient will need good medical care so that he, or she, may be in condition to go through the arduous treatment necessary.

In the fourth place, during the period of convalescence following the treatment, further medical care, advice, and guidance will be necessary; and this should be in the hands of the family physician.

In the fifth place, from this time onward, the patient should make periodic returns to the family physician so that any possible recurrence or metastasis may be recognized in its incipency. The family physician can be of no help here unless he is cancer-minded and knows what to look for as possible evidence of either re-occurrence or the formation of a new growth; and again to quote Sir Lenthal Cheate, "A person who is once carcinogenic is always carcinogenic." That should not make us too pessimistic, since he goes on to say that it may take 100-150 years for the patient to develop a new cancer and, of course, most of us would die of intercurrent diseases in the interim. There is every hope that, if the primary growth can be destroyed before metastasis takes place, the patient may survive and live his allotted span of years without further development; but this statement does emphasize the importance of keeping the patient who has once had cancer under continual observation. *When the check-up examination is made it should always include a thorough physical examination, and whatever laboratory examinations are indicated.*

What is the cause of cancer? Today we do not know. We do not know whether it is *chemical* and due to individual biochemistry; or is *infectious*.

Certain carcinogenic agents have been reported as existing in our own hormones, for instance, the estrin of the ovary. We do know that women developing breast cancer before the menopause are benefited by sterilization. Metastasis in bone will re-calcify temporarily after sterilization without direct treatment. **However, laboratory investigations have prov-**

en that it takes a tremendous amount of this hormone to cause laboratory animals to develop cancer spontaneously.

The infectious theory has been many times advanced, but never proven, and most scientific findings are against its likelihood. The cause may exist in certain foods, as witnessed by the reports of carcinogenic agents in wheat germ oil. This food theory is not new. Dr. Duncan, many years ago connected with the New York Skin and Cancer Hospital, treated his cancer patients entirely by diet, with some startling, but inconsistent, results. Other observers have noted the large incidence of intestinal cancer in the case of the Japanese, who live on garden truck grown under night-soil, but who are extremely cleanly about their person, and who develop very little skin cancer; while the Hindu, who boils his water and eats nothing but cooked food, is reported to have little intestinal cancer, while, on the other hand, he develops considerable skin cancer and is, contrary to the Japanese, rather filthy about his person.

There is a *hereditary* tendency to cancer. A number of years ago Maude Slye, a woman scientist working at the University of Chicago, reported that she could breed cancer in and out of mice by following the Mendelian Law. She found that cancer is a recessive characteristic, and could be bred out of a strain of mice, and that likewise she could breed and develop a cancer-resisting strain. She made the startling statement that, if she could be given the human race for three generations, she could wipe out cancer. Of course, you and I know that no one can control the human race and its matings. Dr. Herbert L. Lombard, of the Massachusetts Department of Health, made a study on the familial aspects of cancer and showed a small, definitely higher percentage of cancer appearing in people whose immediate family gave a history of cancer, as against those with a negative history; and this study also showed that if a person from one of these families developed cancer there was also a striking likelihood that it would be in the same organ as his or her parent.

We know that coal tar and some of its products can be used as carcinogenic agents, and

it is possible that some of the increase in cancer in this day and age may be due to the large part that coal tar and its products play in our daily life. For instance, there has been a marked increase in the number of cases of cancer of the lung. We have attributed this rise not only to the fact that more people are living to a greater age and cancer is increasing not only in the lungs, but elsewhere; but also to the fact that advancement of diagnosis by x-ray and the bronchoscope is bringing more cases to light. It is also possible that products of gasoline, combustion of fuel oil, and benzene compounds of a similar nature enter into the air and are breathed by us today, and may, in those susceptible to cancer, cause it to develop in the lung.

All that we know definitely so far is that cancer is an overgrowth of cells in some part of the body. As Dr. Clarence Little has graphically described, the growth at first is harmless and symptomless, and may be due to a relaxation of growth inhibition in the cells of the body where the cancer develops. He states that if the normal human body continued to grow for fifty odd years at the rate that the infant grows, one human being would easily occupy most of the State of New Jersey. There is an automatic check, therefore, upon cellular growth normally occurring in the human body; and so we reach maturity and cease growing at a definite age. Thereafter, cellular growth merely replaced the wastage, and we are in a state of cellular stability.

Now, if this neurogenic or hormonogenic growth control is destroyed or inhibited in any part, location, or organ, then the cellular growth does not stop with the mere replacement of worn-out cells, but continues without restraint until the additional growth causes cellular destruction, toxin formation, pressure on other organs, erosion of blood vessels, etc. We do know, from observation, that chronic irritation may destroy this growth inhibition. Again, however, it seems that this chronic irritation causes tumor growth not in every one, but apparently in those who are, for an unknown reason, susceptible.

THE PRE-CANCEROUS LESION

I have stated previously that the general practitioner or family physician must be on constant watch for the pre-cancerous lesion. The State of Massachusetts Cancer Commission has proven very definitely that proper education of the population will definitely lower the cancer death rate. How does this educational work do this? Massachusetts found that promiscuous advertising in the newspapers, by the radio, and through posters was of little avail. But if it could arouse its citizens so that men's clubs, women's clubs, churches, and other organizations became sufficiently interested to secure advice from physicians, and would hold forums before which a physician appeared to discuss the subject of cancer, then the population would seek out their family physicians and present to him sluggish sores, small lumps, and growths which in many cases were not cancer but were pre-cancerous. They would go to their family physicians and tell them of slight bleeding and discharges from various locations which might, or might not, be cancer, but which, if eradicated in the pre-cancerous stage, would prevent the development of a new growth. Therefore, the *pre-cancerous* lesion is of tremendous importance.

Time will not permit for me to take up all of these pre-cancerous lesions, but a few examples will illustrate what I mean.

CASE 1

About fourteen years ago a woman presented herself to me with a small lump underneath the skin at the junction of the breast and chest wall. The physician to whom she had first presented herself had told her that he did not believe it was cancer,—“We will just watch it.” I explained to her that all growths appearing in, or near a woman's breast were not cancer, but many of them became so, if they were not originally cancer. “So why watch it?”

It was a comparatively simple operation to remove this small lump. It was put under the microscope, and right in the center of it was beginning cancer. Radium was placed in the wound and after its removal the wound healed and now, after fourteen years, the woman is still alive and has, so far, shown no evidence of re-occurrence, metastasis, or new growth. To have sat by and waited until that lump became a cancer which anyone would recognize would have vitally diminished her chances of survival.

CASE 2

A number of years ago, a male patient presented himself with a very evident cancer of the lower

lip, and with palpable glands already present beneath the jaw. He told me he had gone to his family physician with a small, horny lump, and his physician had removed it twice with a pair of tweezers. Treatment of this case proved of no avail, but had that lesion on his lip been recognized as a pre-cancerous growth when first seen, the man might still be alive and well today.

A pre-cancerous lesion on the skin can be treated adequately in a great many different ways, but it has to be removed, whether that removal be by the knife, by radiation, or by caustic;—it cannot be half treated, and if the chronic sore does not respond quickly to lotions or ointments, it should not be irritated by inadequate caustics, nor should it be half operated; neither should the patient be told that it amounts to nothing—"Let it alone and we will watch it." There are many moles which are congenital, which are harmless and can either be left in situ or removed easily by the cold knife, or by the electric knife; but no one should tackle these unless he knows the different types; and when in doubt, they should be left alone, but should be considered as possible pre-cancerous lesions; and if it is in a site subject to irritation, as from the collar or the belt, the patient should be referred to someone who can make the distinction between the harmless mole and one likely to give trouble. I do not believe that any chronic sore, lump, mole, or wart should be ignored, especially the senile keratosis and the sweat gland cyst. It should be studied by the family physician with the idea of removal by himself, if he feels competent to make the decision as how to treat and remove it, or to refer it to someone who can make the proper decision. The appearance of a lump in a woman's breast should never be ignored, no matter what her age. One out of eight women will die of cancer and that cancer will appear in the vast majority of cases either in the breast or in the uterus. So-called "benign bluedome cysts" have been shown to harbor cancer cells within their lining. All lumps appearing in a woman's breast should be considered either cancerous or pre-cancerous, and should, therefore, either be removed or treated, according to the final decision by those who know, after proper study which may necessitate a biopsy.

I once was connected with a hospital which had an attending physician who never failed to take a Wassermann on any patient, no matter why they came to him. Many colleagues laughed at him and said, "Never send your wife or daughter to Dr. ———, because he will be sure to take a Wassermann." Nevertheless, Dr. ——— chalked up many more cases of syphilis than did his colleagues. I would like to see every man in this room doing general practice persuade every woman patient coming to him, thirty-five years of age, or over, to submit to a vaginal examination, no matter what complaint they come to him with, and then if he can have that same woman submit to such an examination every six months to a year following that first visit, he would pick up a surprising number of early cancer of the cervix; but better yet, he will recognize a lacerated cervix or eroded cervix, or an endocervicitis; any one of the three being pre-cancerous. If he does make these examinations and either treats the lesion himself or refers them to others to treat, he will be the cause of saving the life of many a woman whether she knows it or not. In the same way, if the same general practitioner when he delivers a patient of a baby and finds the cervix torn will make every effort to see that this woman has a repair of her lacerated cervix, either three or four months after delivery, or if she is likely to have several more children, then at the end of her childbearing period; he will prevent many a cancer of the cervix. He should impress upon that woman the importance of having this done and not just pass it up with a statement that: "Some day you ought to have a repair job."

I am extremely pessimistic, so far, in regard to the subject of cure of gastric cancer. We hear a great deal about the value of the early diagnosis of stomach cancer and how much can be done if we can only get people to come to the doctor when they begin to have a little indigestion, failing appetite, or gas distention in middle life, or later. A recent article put out by the Larger Clinics on this very subject proved, upon analysis, to show about ten per cent prolongation of life beyond that which a sufferer from cancer of the stomach might

expect to have without operative interference. The time may come when there will be adequate treatment for early diagnosis in such cases but, nevertheless, much can be done for a pre-cancerous lesion in gastric carcinoma. While in many cases a benign ulcer of the stomach remains benign, there are other cases which bear out completely our idea that chronic irritation causes cancer. The treatment of a stomach ulcer should not end with the prescription of a Sippy diet. Many stomach ulcers will yield to rest in bed and diet completely, but that patient with symptoms would be checked by x-ray examination, for if the ulcer remains, and many of them have remissions in which the patient is symptom free, it is a source of chronic irritation and if the patient is susceptible to cancer it may develop in the margins of the ulcer. If the patient, upon first examination, has already a fairly well developed cancer, the chances of cure by operation are not very great, but if he is in the lower age brackets, and he is agreeable, it is worth the gamble to operate, since his expectation of life without operation is, at the best, two and one-half years, while if he is in the upper age brackets with a relatively short life expectancy, it may be more charitable to let it alone unless he is obstructed. There are also pre-cancerous lesions in the intestines, such as polypus and ulcerations. These two, if discovered, should be properly examined and treated or removed, since they may lead to cancer. One of the most easily examined, and yet neglected, portions of the alimentary tract is the anus and rectum. Many a case has presented himself to his family physician complaining of bleeding and pain on defecation only to be handed a box of rectal suppositories supposedly for hemorrhoids, when the fingers would find a growth. Carcinoma of the rectum or anus is accessible and frequently slow-growing and amenable to treatment in the early stages. Furthermore, hemorrhoids, themselves, should be considered as possible carcinogenic, and yet there are so many patients who allow themselves to suffer from this condition which is easily remedied. Having spoken of the lower alimentary orifice, we must not neglect the upper. There are many cases of mouth cancer which can be pre-

vented by the general practitioner through advice on oral hygiene, and insistence by him that the patient have proper dental attention. There are parts of the pharynx and larynx which our average general practitioner cannot properly visualize; and cases of hoarseness, unless quite temporary, should always be referred to a laryngologist, since here again is a fruitful source of early cancerous lesions which can be cured, and of pre-cancerous lesions which it is even more important to find.

With our present knowledge and methods of treatment, cancer occurring in organs such as the pancreas, gall-bladder, liver and spleen can practically never be cured and seldom alleviated, although there are cases on record of cure of cancer of the pancreas by proper radiation. Chronic gall-bladder disease may be a pre-cancerous lesion and patients should be urged not to put up with a definitely proven chronic gall-bladder for this reason, if no other.

There is another group of malignancies allied to cancer which we must briefly touch upon. They are the leukemias and other diseases of the reticulo-endothelial system, such as Hodgkin's disease and lymphosarcoma. We do not, as yet, know the pre-malignant lesions in this group of cases, but the physician should familiarize himself with the common symptoms of Hodgkin's disease and of the leukemias, which are fairly common in this county, and he should make an effort to obtain a biopsy in cases with multiple glands and a blood count in the cases of loss of weight and anaemic appearance with the idea in mind that any of these conditions may be present. Radiation in small doses often completely relieves, and life can be lengthened for years.

The subject is so vast that one cannot in one short paper, or one long one for that matter, try to cover the entire subject of what the man in general practice should look for if he is cancer-minded, but I believe a few high points have been touched upon to show how much a family physician can do to ward off cancer, and to find it in its early stages, and to thus not only increase his practice but to secure the gratitude and confidence of his patient, and to do his part to lower the alarming increase

in the present cancer rate in our county, our State, and our nation. To sum up, may I list a few simple symptoms of malignancy and pre-malignancy: (1) A lump appearing beneath, or on, the surface anywhere, but particularly in a woman's breast; (2) slight discharge from the nipple, so-called "Paget's disease", is not exzema but is duct carcinoma; (3) any retraction or cracking of the nipple; (4) a slight thickening or cornification or fissure on the tongue, lip, or any part of the oral cavity; (5) a sore isolated, crusting or scabbing on any part of the body that does not heal; (6) a sudden change in the form of a growth of a mole, wart, or wen, any one of which should also be considered, without growth, as a pre-cancerous lesion; (7) any discharge from the female genital organs other than a normal menses, especially abnormal menopausal bleeding; (8) blood in the urine, gross or microscopical; (9) unexplained indigestion, with loss of appetite, especially for meats, occurring after the age of thirty-five; a tomach ulcer that does not respond to medical treatment; (10) a feeling of fullness or uncomfortable-ness in the rectum, or any type of persistent discharge, bloody or otherwise, from that organ, and this includes persistence of hemorrhoids; and remember the statement by the patient that he has hemorrhoids does not make the diagnosis; (11) persistent and unexplained discharge or bleeding from the nose.

As Chairman of the Cancer Control Committee of The Medical Society of New Jersey, I am particularly anxious that the medical profession as a whole, become cancer and pre-cancer-minded. This means study and application on the part of many of us. There are agencies of all types, from the Federal Government down, who have become aroused over the alarming number of cancer deaths, and the population is being urged to do something about it. It would be tragic for that population to be urged to go to their family physician and find him uninterested or unintelligent in regard to the subject. Education of the population is futile until the medical profession itself is aroused. While we need in this State as a whole increased facilities for the treatment of cancer, especially along radiologic lines, a great deal can be done which is not being done to recognize pre-cancerous lesions, to advise people what to notice and what methods of life to pursue to avoid the production of cancer; to make an early diagnosis of such lesions as can now be adequately treated, and to get such cases early into the proper hands. The family physician has not been eliminated in the treatment of cancer. He is needed more than ever, not only to find and refer the case, but to ward off the production of new cancers and to give adequate medical care during and after the specialist's treatment.

FETAL RESPIRATION AND ITS RELATION TO ASPHYXIA, ATELECTASIS, AND PNEUMONIA OF THE NEWBORN

By FRANKLIN F. SNYDER, M.D., Chicago, Ill.

Read before the Combined Sections of Obstetrics and Gynecology and Pediatrics of The Medical Society of New Jersey, Atlantic City, N. J., June 6, 1939.

The time has come for the rewriting, in the current textbooks on obstetrics and pediatrics, of the chapter which deals with injuries of the respiratory system. New evidence has come to light of anatomical and physiological changes in the lungs during intrauterine life, and as a result there are fresh clues to the pathogenesis of certain familiar abnormalities of

the respiratory organs of the newborn, namely, asphyxia, atelectasis, and pneumonia.

Since these injuries are evident at the time of birth, it follows that they must originate during intrauterine life. The problem is to explain how these complications involving the respiratory system can occur while the fetus is still within the uterus. Therefore, in order

to trace the transition from the normal state of activity of the respiratory system to that which is pathological, one must observe the fetus before birth. This involves resort to experiment.

I would like to illustrate the methods and results of direct observation of the fetus in the intrauterine environment. This work was done with Dr. Morris Rosenfeld of the Department of Pharmacology of the Johns Hopkins Medical School.

We began with an attempt to resuscitate asphyxiated babies by the injection of respiratory stimulants. No success was met, although it was difficult to determine the cause of failure.

Next, we tried animal experiments.

The uterus was exposed by laparotomy, and the fetuses within the uterus were injected with a series of respiratory stimulants—cyanide, caffeine, coramine, a-lobelin, ergotoxin. There was no success in stimulating the fetuses.

We were somewhat surprised at this failure to arouse the fetus from a state of apnea for two reasons: First, various traumatic factors associated with delivery had been eliminated since the fetus was studied before the onset of labor; and second, in the rabbits we studied, prolongation of pregnancy had been accomplished by the injection of pregnancy urine extract, with the result that an experimental animal was available in which fetuses within the uterus could be observed at full term, or at stages of postmaturity corresponding in development to newborn rabbits of one, two, or three days.

In the course of the experiments various anesthetics were used in order to permit exposure of the uterus. Occasionally, as the depth of anesthesia was diminished, a few irregular respiratory movements of the fetuses were noticed. These gasps tended to confuse the results of the experiments with stimulant drugs. It was decided to eliminate general anesthetic agents entirely. Accordingly, section of the lumbar spinal cord was done to produce loss of sensation over the abdominal region incised at laparotomy.

The first experiment carried out with this new technic, namely, inhibition of labor and

elimination of anesthetics, disclosed the errors of experimental methods heretofore used and revealed the *intrauterine* origin of respiration.

Fetuses within the uterus were breathing actively. Rhythmical excursions of the chest and diaphragm continued throughout periods of observation lasting many hours. Through the thin uterine wall of the rabbit we could distinguish unmistakably that the movements were respiratory.

Many questions now arose regarding the relation of fetal respiratory movements to the injuries of the respiratory system which are evident at the time of birth. In order to throw light upon the etiology of respiratory failure at birth and the pathogenesis of injuries of the lungs such as atelectasis and intrauterine pneumonia, it was essential to determine first the factors which normally regulate respiration in the intrauterine environment.

I would like to illustrate our methods and results with the aid of motion picture records and a few lantern slides.

(Here follow two reels of motion pictures.)

In one reel, the breathing of rabbit fetuses within the uterus is readily seen, since the uterine wall becomes thin and transparent in late pregnancy, permitting a direct view of the fetuses. In the second reel, breathing is shown to occur also in the human fetus long before birth.

From the foregoing evidence it is clear that failure of respiration at birth represents the suppression of previous activity of the fetal respiratory system, rather than the failure of some new mechanism to come into operation.¹ By experiment, it is found that three main types of fetal apnea can be distinguished, namely,—anoxemic, acapnic, and anesthetic.² The problem of respiratory failure at birth involves, therefore, the recognition and control of these factors in the period preceding delivery. Efforts to maintain adequate oxygen supply before birth, and caution in the choice and use of anesthetic agents, are obviously more effective than later attempts at resuscitation.

In addition to failure of the nervous mechanism of respiration, certain anatomical injuries of the lungs may be present at birth, namely atelectasis or incomplete dilation of the alveoli,

and pneumonia. It has long been noted at autopsy that the lungs of stillborn fetuses contain cellular debris characteristic of amniotic fluid. Recently it has been shown by experiment that there is a tidal exchange of fluid between the amniotic sac and the pulmonary alveoli associated with the respiratory excursions of the fetus. Foreign particles such as India ink introduced in the amniotic sacs of rabbit littermates, enter the pulmonary alveoli of fetuses which are breathing, but in apneic fetuses fail to enter the lungs. Within a minute after injection of the amniotic sac, blackening of the lungs of breathing fetuses is easily demonstrated.



Lung of rabbit fetus showing carbon particles introduced with the current of amniotic fluid entering the lung as a result of intrauterine respiratory movements. Breathing of the fetus was observed directly through the thin uterine wall, and India ink was injected into the amniotic sac. Twenty minutes later the trachea was clamped and fixation in formalin was completed within the uterus to avoid the breathing of air.

In view of the respiratory activity of the fetus, it is evident that contamination of the

amniotic fluid by irritant substances such as meconium, or bacteria may cause inflammatory changes of the lungs before birth and even result in death of the fetus with intrauterine pneumonia. The presence of cellular and sebaceous debris of excessive amounts or abnormal type may lead to obstruction of bronchioles during intrauterine life and result in atelectasis or incomplete dilation of the alveoli of the lungs.³

Furthermore, a new approach to the problem of obstetrical anesthesia is afforded by noting the effect upon fetal respiratory movements of various anesthetic agents which are commonly used during labor. The dosage level at which a given narcotic administered to the mother results in depression or abolition of fetal respiratory movements can be readily determined. At the same time, the hypnotic or anesthetic effect upon the maternal animal induced by the dosage required to depress or abolish fetal respiration, is noted. Insofar as the aim is to obtain analgesia or anesthesia of the mother and to avoid depression of the fetal respiratory system, it is evident that the foregoing method provides a basis for comparison or assay of anesthetic agents which takes into account the peculiar sensitivity of the fetal respiratory mechanism.

The factor of narcosis in the pathogenesis of asphyxia neonatorum may thus be isolated and analyzed.⁴ As additional agents are proposed for trial in obstetrical analgesia and anesthesia, rapid and accurate evaluation of their usefulness may be aided by such tests carried out under the controlled conditions of the laboratory.

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Hospital

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THE DIFFERENTIATION OF TUBERCULOUS AND NON-TUBERCULOUS PULMONARY INFECTIONS

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Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey, in Atlantic City, June 7, 1939.

The differentiation of tuberculous from non-tuberculous pulmonary infections can frequently be a very difficult problem. The diagnosis of pulmonary tuberculosis carries with it a grave dual responsibility, and should never be made lightly. To the patient it always means a very radical change in mode of life, while to the physician it spells a commitment from which it is always difficult and embarrassing to escape, if he happens to be wrong.

Fortunately, there is rarely any need for a hasty decision, for even emergency complications such as hemorrhage, spontaneous pneumothorax, etc., can all be treated symptomatically rather than etiologically. As in many other fields, the percentage of error can be reduced to a negligible figure by a careful, systematic, thorough, and complete study of each case.

HISTORY

In spite of the fact that in both tuberculous and non-tuberculous pulmonary infections the symptoms may be more or less alike, the history of the mode of onset and other features may vary enough to give substantial aid as to the probable diagnosis. The difficulty arises when the objective evidence is atypical, and especially when, in spite of suspicious signs of tuberculosis, the sputum is persistently negative, or the lesion clears up rapidly.

PHYSICAL VS. X-RAY SIGNS

The present-day highly perfected roentgen technic enables us to get evidence that is so superior to that of physical signs, that the latter play but a relatively minor rôle in diagnosis. Their chief importance is to help localize the lesion, and give us some idea of its gross characteristics.

Obviously, correct interpretation of chest films requires considerable familiarity with the pathology of pulmonary diseases and their

x-ray shadows, as well as with those of the normal chest, and the densities of non-pulmonary factors. Single observations are frequently insufficient for diagnosis. Time is most essential in doubtful cases since it affords opportunity to compare serial films. The more recently reported work in visualizing the pulmonary vessels and the heart chambers with massive intra-venous injections of contrast material should rarely be necessary.

The comparatively rapid resolution of a questionable upper lobe lesion soon dispels the fear of tuberculosis; while the persistence, after a month or more, of a primary basal lesion increases the fear of the probability of tuberculosis.

The history can, of course, be very ambiguous and misleading. That of contact must be taken for what it is worth. There may have been exposure to tuberculosis, and yet the patient may not be tuberculous,—and vice-versa. A history of pleurisy may have more value but still has its limitations. Even hemoptysis can occur in many non-tuberculous lesions, as may physical signs and x-ray findings limited to the upper lobe. In such cases the demonstration of tubercle bacilli would be the only diagnostic criterion.

It is, therefore, axiomatic that in all pulmonary disease the examination of the sputum for tubercle bacilli should be routine and repeated. Occasionally the transient presence of a positive sputum may be of only passing interest, as for example, when an old dormant caseo-calcareous or fibrotic lesion is shelled out by a suppurative non-tuberculous process.

There are a number of conditions that resemble pulmonary tuberculosis in symptoms and signs that are not caused by tubercle bacilli; and there are forms of pulmonary tuberculosis that do not follow an orthodox pattern.

UNRESOLVED AND ATYPICAL PNEUMONIA

One of the most frequent causes for anxiety and possible error lies in the similarity between an unresolved upper lobe pneumonia in an ambulant patient, and pulmonary tuberculosis. Under such circumstances, the error is usually the result of a hasty conclusion. On the other hand, a primary lower lobe tuberculosis is likely to be overlooked and regarded as an unresolved pneumonia, and thus lead to the error of delay.

develop a question which would never face the physician at the bedside in a much sicker patient. In all these cases, tuberculosis must be considered until excluded. As a rule in non-tuberculous infection—unless we are dealing with a progressive suppurative process, putrid or non-putrid—further observation, with bed-rest, will usually reveal a favorable course with a clearing of the x-ray findings in about two weeks. Exceptions to this will be encountered in spreading suppurative infections going on



Fig. 1.—Case one. September 26, 1938. Elsa A. Unresolved pneumonia. A college student, sent home on account of fever, with pulmonary symptoms. There was considerable anxiety created by possible previous family exposure to an uncle with tuberculosis. Note the lesion covering the inner half of the right apex, where the physical signs were all anterior.



Fig. 2.—Case one. Elsa A., on October 13, 1938. Note the marked degree of resolution seventeen days later. The Mantoux test in this patient was negative.

An exudative density in the upper lung field has always been a diagnostic problem. When coupled with pulmonary symptoms of a sub-acute character, the suspicion of tuberculosis becomes intense indeed.

Symptomatic differences between tuberculosis and unresolved pneumonia are not dependable. Similarly differential details in the x-ray densities can also be misleading, in spite of the fact that in tuberculosis these are usually mottled and moth-eaten, and likely to be cavernous; while in non-tuberculous exudates they are more likely to be homogeneous.

Both forms of infection may begin with a history of a "cold". Patients suffering with either may walk into the clinic or office, and

to the formation of a putrid lung abscess. Failure to resolve after a few weeks should increase one's suspicions, and these will usually be clinched by a positive sputum. Certain points must here be emphasized in connection with sputum studies.

1. The collection must be of sufficient size, and contain expectorated bronchial and not post-nasal secretion.
2. When repeatedly negative, large amounts must be collected for digestion and concentration.
3. If after the above procedure the sputum is still negative, gastric lavage must be resorted to. This must be done before breakfast, with the removal of the fasting contents.
4. Finally, a sputum can not be definitely considered negative until it has been submitted to culture or guinea pig inoculation, preferably the latter.

As a further aid in diagnosis, I have found the use of antero-posterior films in addition to the conventional postero-anterior, very helpful. As a matter of fact, it is surprising that we still continue to make postero-anterior films routinely in the face of the fact that most tuberculous lesions are found in the posterior lung fields. Ordinarily the composite picture made postero-anteriorly is sufficient to disclose lesions gross enough for diagnosis. However, in the doubtful cases, the film close to the lesion will reveal early soft densities which might escape observation altogether, or be indistinct, when they are pictured in the postero-anterior position. This is particularly true of small lesions in the apex sometimes hidden by the anterior ribs and clavicle when they are pro-

may be more significant of an unresolved non-tuberculous infection.

FOREIGN BODIES

Foreign bodies in the lungs must be considered because of the associated infection that usually follows their aspiration. Anything blocking a pulmonary segment may be regarded as a foreign body, be it something inhaled, or a local bronchial neoplasm either benign or malignant. This may be followed by an obstructive emphysema or atelectasis. In atelectasis "lung drowning", or collapse with infection may follow, and a putrid lung infection may develop. A fluid level in a localized area is characteristic. The bronchoscope is often diagnostic. Fluoroscopic localization is valu-



Fig. 3.—Case two. Ruth L., aged 33. Foreign body (tooth) in bronchus. January 8, 1932. This woman was referred with a diagnosis of pulmonary tuberculosis, which was at first confirmed on roentgenological and clinical findings. Subsequent studies one month later revealed atelectatic changes in the left upper lobe, which led to the discovery of a foreign body, as shown in the illustration.

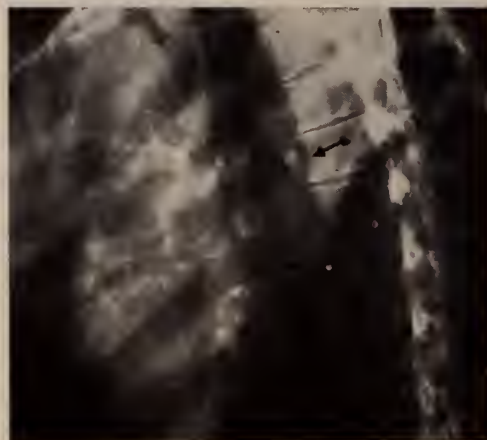


Fig. 4.—Case two. Ruth L., on February 13, 1932. The foreign body proved to be a tooth, which was subsequently removed through the bronchoscope. This was followed by complete recovery.

able for an optimum roentgenogram, and also as an aid in the surgical approach, if one is necessary.

FUNGUS INFECTIONS

jected forward, or small thin-walled cavities near the hilus. For a better study of lesions near the hilus, the antero-posterior lateral stereoscopic exposure, according to the method of Carlos Santos of Lisbon, Portugal, is of considerable aid.

French observers long ago pointed to the "zone of alarm" posteriorly toward the apices as the frequent site for the first signs of moisture in pulmonary tuberculosis. Conversely in the majority of cases, the discovery of fine râles, anteriorly, above and below the clavicle

Infections with various forms of fungi are becoming more prominent in the literature, and can simulate acute and subacute pulmonary infections of pneumonic or tuberculous nature. In the face of the persistent negative sputum, these cases with signs of bronchopulmonary infection must be identified by bronchoscopic studies of aspirated secretion. Only thus obtained are bacteriological studies of any value, since mouth contaminants must be excluded.

SINUS DISEASE

Disease of a sinus is usually associated with cough due to some other upper respiratory factors such as nasopharyngitis, laryngitis, and bronchitis. Little difficulty is encountered unless the x-ray happens to reveal an aspiration infection of the lungs. The left lower lobe seems to be particularly prone to involvement by aspiration. This may be due to the more direct downward course of the air currents during inspiration on the left than on the right side. The uniformity of the exudative density is of considerable aid in the recognition of such lesions. These cases are apt to be subacute, and are frequently encountered in ambulant patients. Transillumination of the antra, checked with a fluoroscopic study, should be routine, and are of great aid in detecting sinus involvement. Final confirmation must be left to the rhinologist. The aspiration infections in these cases, even though pneumonic in character, usually resolve within two or three weeks, are accompanied by negative sputum, and, surprisingly enough in many cases in adults, show a negative Mantoux test.

BRONCHIECTASIS

Because of its chronicity with waxing and waning of symptoms, and occasional bleeding, bronchiectasis is likely to be mistaken for tuberculosis, but not as a rule very long. If there are no inflammatory bronchopneumonic exudates, the negative x-ray clears up most of the doubts. In the presence of variable exudates, final decision will depend upon a persistently negative sputum, and as often happens, a negative Mantoux reaction. An old history of prolonged or recurrent pneumonia, followed by clubbing and a confirming bronchogram, will help determine the diagnosis. The cases of pulmonary tuberculosis in which bronchiectasis is a complication of the original disease, will rarely offer any problem.

LUNG ABSCESS

There are two kinds of lung abscess—the *putrid*, and the *aputrid*.

A careful history is of great value from an etiologic standpoint. The *aputrid* form is rarely a problem, and is usually discovered accidentally in a routine x-ray of the chest in

the course of pneumonia, especially if it is prolonged, or is followed by the expectoration of sanguinous pus. The course is brief and favorable.

The putrid form can usually be associated with the aspiration of foreign matter in connection with oral surgery, tonsillectomy, a dental extraction, anesthesia, submersion, deep intoxication, convulsive seizures, or choking on food, etc. The characteristic odor, serial x-ray studies, bronchoscopic findings, and persistently negative sputum, together with the characteristic course, rarely leave any doubt. Difficulty will occasionally be encountered when the case is seen early, before the development of a fluid level or putrid expectoration.

ACUTE PNEUMONIC TUBERCULOSIS

An acute pneumonic tuberculosis may commence like any other form of pneumonia, and be very misleading. However, the absence of pneumococci, the presence of marked sweating with early bubbling râles, the frequently intermittent temperature, and a clinical appearance differing from that of pneumonia, may arouse a suspicion of tuberculosis which will soon be confirmed by the discovery of tubercle bacilli. In less toxic cases, the persistence of consolidation, with the peculiar moth-eaten and mottled appearance of the x-ray shadows, will also raise the question of the possibility of tuberculosis.

PRIMARY LOWER LOBE TUBERCULOSIS

Primary lower lobe tuberculosis may be encountered in two forms, each difficult to diagnose early in the face of a negative sputum. Rieser has described these two forms very well, and emphasized their frequency in women. Because of the anatomic position of the apex of the lower lobe, particularly on the left side, the lesion is likely to be overlooked until it has extended beyond the left cardiovascular border. Antero-posterior stereoscopic studies are particularly valuable here.

The mode of onset and the early course may resemble that of pneumonia very closely. This is particularly true in those cases where the consolidation is limited in extent, and well confined to the base of the lower lobe.

Unless tubercle bacilli are found, the true

nature of the lesion may go unsuspected for weeks until its persistence or tendency to cavitation will suggest the probability of tuberculosis.

CONCLUSIONS

1. The differentiation between tuberculous and non-tuberculous pulmonary infections is often exceedingly difficult, and demands the greatest conservatism.

2. A positive diagnosis of pulmonary tuberculosis is not justified without evidence that will warrant it.

3. The limitations of history and physical signs, in contrast with the greater diagnostic value of the x-ray and sputum examinations, are stressed.

4. The diagnostic value of serial and close-up films in doubtful cases is emphasized.

DISCUSSION

DR. SAMUEL COHEN, JERSEY CITY, N. J.

There is a very important diagnostic feature roentgenologically, and that is the length of time it takes for a particular pulmonary infection to resolve. If it is a lobar pneumonic condition, such as pneumococcic pneumonia, the process will resolve in a period of three weeks; whereas, if it were a tuberculous pneumonic lesion, the resolution would go on over a much longer period of time if it ever does resolve itself, so that serial roentgenograms would be of help in the clinical course.

Another point in this connection is the fact that as this pneumonic lesion resolves over a period of three weeks, it doesn't leave any residue on x-ray; whereas, if you follow a tuberculous lesion on x-ray

over a period of weeks or months, you almost invariably get some evidence of residue in the form of fibrosis, and as time goes on, perhaps calcification.

Those of you who are further interested in the problem might find it of value to look at some very interesting cases that a group of workers from the Prudential Insurance Company have put up in one of their exhibits; particularly the ambulatory people who complained of upper respiratory infections and who on ordinary chest film showed areas of pneumonitis in the lung which might very easily be interpreted as tuberculosis and, if you are still further interested in them, you might pay our own exhibit a little visit, and I think with some profit.

41 Emory Street

THE DOCTOR SHARES A RESPONSIBILITY IN ADOPTIONS

THE ADOPTION OF CHILDREN—ARTICLE NUMBER TWO

By ELLEN C. POTTER, M.D., Director of Medicine, New Jersey State Department of Institutions and Agencies, Trenton, N. J.

The physician in his own right is usually the first person who hears of a child potentially available for adoption. He must "do something about it"; he knows of childless couples whose happiness would be complete if the "right child" could become their own; he knows the unmarried mother may or may not wish to give up the child; he knows she will want protection from prying eyes, sometimes even from those of her own family; and he is almost certain that there will be a financial problem involved, the least of which will be his own professional fee.

He knows also that, because of the urgent demand for babies for adoption, there has

grown up a racket, with which he cannot afford to have his good name smirched.

He does not consider himself a lawyer or a social worker, but he knows there are technicalities about the adoption law which must be met if the procedure is to be carried through without a hitch.

How can he handle the situation, to do the good things he wants to do for the unmarried mother, the baby, and the adopting parents; and at the same time protect his own good name from any suspicion of commercial or illegal dealing?

We give you the true story of Betty to show

how one physician handled his knowledge of a "potential child" for adoption.

Betty was an attractive, stately blonde of nineteen, from a family esteemed in the community. She was a high-school graduate, employed in a busy down-town office; looked upon as a responsible citizen.

In deep distress she went to the family doctor for help. She was pregnant, and because of her position in the community and financial limitations, she had made up her mind that adoption of the child was the only solution.

Knowing the family, who were his patients, the physician quickly grasped all the problems involved and, encouraging Betty, agreed to do what he could to help.

First he wrote to a state-wide incorporated child-caring agency of which he had heard. His letter was short: "I've a patient who wishes to place her child for adoption. Can you offer any suggestions?"

The agency immediately came to him for an interview through a social worker on its staff. He told the story as he knew it; and assured that all information would be held confidential, that no person would be contacted without Betty's consent, he talked freely.

He was asked that he keep the agency advised as to the progress of the case; that at the time of delivery a cord Wassermann be taken; that any unusual circumstances occurring at the time of delivery be reported.

The physician arranged with Betty for an interview with the social worker and with his reassurance a friendly, helpful relationship was established and on a basis of confidence the best plan for the child was worked out.

In this case, Betty and the natural father were both willing that he be interviewed, and it was recorded that the father was a gifted musician, not a ne'er-do-well, with physical or mental taints perhaps transmitted to the child. (Given other circumstances, the putative father would not have been interviewed, but it is essential that it be known what kind of a man he is, not necessarily his name and address.)

The months slipped by and with a choice as between a licensed maternity home or a boarding home with delivery in a hospital, the physician chose the former as more suitable to

the case and out of easy reach of the home community.

Delivery safely passed, Betty still felt sure that the adoption plan was the best for the child, and at the end of ten days the social worker came to take the infant for care and placement, not yet for adoption but for observation.

Here the law entered into the transaction. A formal notarized consent signed by Betty was required assigning the child for adoption with the incorporated child-placing agency which accepted full responsibility for the child. Then the baby was removed and placed in a carefully selected boarding home, where the social worker watched the child's development under the tender, intelligent care of the foster mother under a physician's guidance.

When they were sure that the child was developing normally, the worker began to think in terms of those childless families for whom the agency wanted to provide just the right child.

The difficulties which might be encountered in placing the child in the home town of the mother where the doctor practiced were faced and ruled out. The families which he had in mind were discussed with the social worker; and he was urged to make it clear to them that it took time and patience to find just the right child for adoption because there were not enough normal babies to go around. At all events these families could be served by the agency although *this* baby was not for them.

Then the agency reviewed its long waiting list of those seeking children for adoption and an interview was arranged for the social worker with those families which seemed most likely to meet the needs of this particular child.

Six months after the baby was accepted by the agency the adopting parents were "introduced" to the child in his foster home and the final decision was made by them and the agency as to whether this was the child for them. Only a period of trial in the home would settle this; and the agency, still legally the "next friend" of the baby occasionally through the worker made friendly visits to the adoptive home to help in any adjustments necessary to be made, and their family physician was em-

ployed to follow the health and welfare of the child.

At the end of a trial year (which the Court may reduce to six months in the interest of the child) came the great day when the petition for the right to adopt was heard and approved without question, for the report made to the Court by the agency resolved every doubt in favor of this adoption.

The details of the record in the files of the agency and of the Court were carefully guarded; the adjustment of the birth certificate was

made according to law; and a healthy, happy child was made one with a family which sought him and loved him.

An incorporated child-caring agency, if trusted by the physician, can extend his good will to those in need of help on both sides of the delicate problems involved in adoption, saving him untold hours of labor in working them out to a satisfactory conclusion.

But what does happen when the legal provisions of the Act are not met? That is another story!

THE TECHNIC OF GASTROSCOPY AND INDICATIONS FOR ITS USE

By ANDREW J. V. KLEIN, M.D., Newark, N. J.

Read before the Section of Medicine and Pediatrics of the Academy of Medicine of Northern New Jersey.

Though much is now being written about gastroscopy, it is far older than its diagnostic ally,—the x-ray. Its history is plentifully seasoned with such names as Kussmaul, Nitze, and Mickulicz, and later Einhorn and Jackson. These men worked with all the difficulties and dangers of a rigid tube. It was Georg Wolf, guided by the vast gastroscopic experience of his predecessor, Rudolph Schindler, who finally ground the myriad lenses that make up the flexible instrument in use today. Since 1932, over a million gastroscopies have been performed. Few outstanding clinics have not adopted its use, and modifications of the instrument have come to us from all parts of the globe.

Passing the instrument is simplicity itself. The success of the examination consists in convincing the patient of this. I have not found any ideal topical anaesthesia for gastroscopy. It is ridiculous to expect to transform an apprehensive or uncoöperative person into a "good patient" by making his lips, tongue, and throat dry and numb. I also prefer leaving the patient fit to return to his normal daily routine immediately after the examination. For these reasons, therefore, in 256 gastroscopies the last ninety-six received no anaesthesia whatsoever. Subcutaneous injection of codeine and atropine did not seem to help the examination appreciably.

My technic for emptying the stomach is in keeping with this policy of simplicity. With gentle suction and frequent changing of posture, a nurse trained in passing stomach tubes empties the stomach by trolling for secretions. I use a large tube, since its size double checks on my previous fleuroscopic study of the esophagus. I also like a stiff tube because, without the patient's aid, it goes down so fast there is little retching. Thus mucus and regurgitated bile are not churned into an impenetrable foam. In fact, with nervous or very ill patients, I have not emptied the stomach at all, and have been able to see quite well. While passing the scope, I prefer the head guided on the pillow by the reassuring dexterity of the nurse rather than held in any vice-like grip.

A brief word regarding the place that gastroscopy has in our clinics. In order of importance the indications are as follows:

1. To differentiate the gastritides.
2. To follow the course of gastric ulcer.
3. To investigate the post-operative stomach.
4. In x-ray of doubtful cases.

Discussing these indications in reverse order; cases in which the x-ray is doubtful or misleading are comparatively few. Occasionally the gastroscope will unearth a gastric ulcer or carcinoma, but with a careful fleuroscopic study this is unusual. With the popularity of

gastrectomy where the stoma is rarely missed, the post-operative stomach is becoming less a problem. A gastro-enterostomy stoma is seen in its entirety with much more difficulty as are anastomotic ulcers after this type operation. In either case, landmarks are completely disrupted. I have not found post-operative gastritis as often as reported.

The gastroscopic study of gastric ulcer yields two results. Many ulcers showing complete x-ray healing have far from complete epithelialization gastroscopically. A smaller group shows a persistent niche in the x-ray which the gastroscope proved to be a healed puckered scar.

In any clinic of considerable proportions a small percentage of patients will have real pathology detectable by time-honored methods. The vast majority have been coming back to clinic for years with a diagnosis of "nervous dyspepsia" or "chronic gastritis". This was pardonable in the past, especially since indiges-

tion is left out of few symptom complexes; and arm in arm with the large bowel, the epigastrium consorts with many neuroses. The gastroscope and the fractional test meal are gradually putting gastritis on a scientific basis. Hypertrophic, atrophic, and superficial gastritis are really descriptions of what we see with the gastroscope. The correlation of these types of mucous membrane with types of secretion, acidity, volume, and quantity of mucus and pepsin, is now going on. From here the horizon quickly stretches out. Already we have begun to fit these clear-cut findings into constitutional patterns. An atrophic gastritis may be an atrophy in response to a hyposecretory constitution. I doubt whether, like the cardiologist, we will ever be able to pigeon-hole our patients in Class I, II, etc. If, however, the gastroscope is to live with us, in clinical medicine, it will do so not on its merits of wayside detection, but in rescuing the vague dyspeptic with organic disease from the classification of "neurotic".

15 Prospect Street

MANAGEMENT OF THE THIRD STAGE OF LABOR

MATERNAL WELFARE ARTICLE NUMBER FORTY-THREE

By JOHN FRANCIS CONDON, M.D., Newark, N. J.

The fourth of a series of five papers read before the Section on Obstetrics and Gynecology of the Academy of Medicine of Northern New Jersey, March 2, 1939.

In the short space of time allotted to my topic, I will confine my remarks to the importance of an intelligent understanding and appreciation of the physiology and mechanism of the third stage of labor, as related to its proper management.

At first glance this may appear quite elementary to the matter; true, but does not the success of any major problem depend upon faithful application of elementary principles? This being a very important major problem, the same holds true here.

To begin with, broadly speaking, our interest and attention should not be delayed until the onset of this stage; but should actually be aroused long before labor begins, or during the prenatal period.

Is it not logical to presume, when conception occurs in a normal woman, when her pregnancy pursues a physiological course, followed by a spontaneous delivery of her child at term, that we should have as a sequence a normal third stage? If not, why? My contention is, should a pathological complication ensue at this time, it can only be attributed to two main causes; namely, first, a lack of the above-mentioned understanding and appreciation of the physiology and mechanism, or a culpable indifference to them on our part; and second, by the very vicious habit of premature attempts to hurry along the expulsion of the placenta by massage and expression. These are two common and unpardonable errors. Further on, a few facts will be submitted to corroborate this statement.

So much for the normal case. Let us now direct attention to the abnormal type. This is one whose history and physical findings in the prenatal period place her in this category; or who during pregnancy develops some pathological syndrome; or again one whose labor was complicated by inertia or terminated by a difficult operative procedure. Should we not, under such circumstances, anticipate and be prepared to encounter a pathological third stage?

"Forewarned is being forearmed", was never truer than under these conditions. It is this fact that is responsible for the admonition that our interest and attention should be aroused before the onset of labor; or during its first and second stages, or earlier.

With the onset of the third stage, the first consideration demanding attention is that we are to deal with two distinct phases during this period. First, there is the placental separation, physiologically brought about, after the birth of the baby, by contraction and retraction of the uterine muscular fibers; and secondly, the expulsive phase, to expel the placenta by the contractile force of the uterus. Inattention to these two important physiological actions is frequently responsible for unnecessary bleeding; and interferes with the normal procedure. Therefore, during the first phase, placental expression is absolutely prohibited; during the second phase, if properly executed, it may safely be resorted to.

After conscientious prenatal supervision, and after a skilful and successful conduct of labor up to this time, unless we manage the third stage along these principles, we are not fulfilling our duty.

The recognized procedure laid down for the management of this stage is as follows:

1. Careful observation of the corpus from the time the baby is born until proper contraction and retraction of the muscle fibers recur, and complete the natural separation of the placenta from its site.

2. Absolutely avoiding any unnecessary manipulations, such as attempts at expulsion of the placenta at this time.

3. Careful inspection of the placenta and

membranes when expelled, to determine that no parts have been retained.

4. Securing and aiding the normal mechanism of contraction and retraction of the muscular fibers, by the use of such oxytocics as ergonovine or pitocin.

5. And finally, of controlling the fundus for at least half an hour, or longer, in order to detect any relaxation of the uterus.

With the abnormal type the management will vary with the causes. But, irrespective of them, anticipation of hemorrhage should suggest that we be prepared to control it, and replace the fluid that has been lost; and treat the anemia and shock that is most likely to ensue. Unless so prepared, our efforts may be futile; as you all know, time is a big factor under such circumstances, and seconds count.

When referring to an abnormal third stage, our attention is immediately directed to the retention of the placenta or parts of it, which always results in excessive bleeding due to the deficient contraction and retraction of the uterine musculature; if not, we are then dealing with injuries of the birth canal. Under such emergencies we are facing two of the three leading causes of maternal morbidity and mortality,—namely sepsis, and post-partum hemorrhage.

Passing over the question of sepsis, let us devote our consideration to hemorrhage, and the bearing which the management of the third stage has in relation to it.

While the loss of half a pint of blood does not constitute an excessive amount, nevertheless, one must bear in mind that the effect of blood loss varies in different individuals. It is the constitutional reaction to the amount lost which endangers the patient's life.

Earlier, I promised to submit evidence to substantiate the statement that mismanagement of this important third stage was responsible, in a large measure, for pathological complications.

De Lee is author of the statement: "More women die as the results of accidents in this stage than of the first and second combined." He wrote that in his first edition twenty-five years ago, and it is of interest that he has not deleted it from the 1938 edition.

Listen to the remarks by Baer, Clinical Professor of Obstetrics and Gynecology, Rush Medical College:

"I have seen an attempt at manual removal of the placenta in which the physician's hand went through a rupture in the uterus and brought forth several coils of intestines avulsed from their mesentery attachment. The placentas of course had previously escaped into the abdominal cavity, through the same rupture."

"I have seen inversion of the uterus which followed violent attempts to express the placenta by pressure on the fundus.

"I have seen uteri quietly distend with enough blood to exsanguinate the patient, and no one the wiser.

"I have seen futile attempts to express an adherent placenta which produced tremendous abdominal bruising and disability.

"I have seen immediate post-partum hemorrhage so profuse that death ensued in ten minutes; and others that were controlled and the patient saved only by a display of magnificent teamwork."

The author, in summarizing the treatment of the third stage, states that "The safe delivery of the placenta is more important to the maternal health than the safe delivery of the fetus."

Reich, of Bellevue, analyzing blood loss following delivery, says that the occurrence of blood loss during and after the third stage might appropriately be termed, because of its seriousness, "Obstetrical Enemy Number One"; for no other accident or complication has such potential dangers, or is encountered as frequently. He may proudly boast that last year this clinic has reduced the incidence of post-partum hemorrhage 50 per cent, emphasizing greater consideration of the conduct and management of the third stage.

Beecham, last Spring, before the Philadelphia Obstetrical Society reported that their Maternal Welfare Committee concluded that 53 per cent of deaths resulting from post-partum hemorrhage in a six-year period were preventable, with the responsibility assigned to the attendant, stressing mismanagement of the third stage.

Abramson and Berman, writing on "Factors

effecting loss of blood during or following the third stage", summarize their article as follows: "None of the factors, however, approaches in importance the management of the third stage of labor in its effect. For it is through improved technic in management that the average blood loss has been reduced from 500 c.c. at the beginning of the century, to about 225 c.c. at the present time."

The American Committee on Maternal Welfare, in enumerating the various factors responsible as exciting causes of post-partum hemorrhage, italicize mismanagement of the third stage.

Post-partum hemorrhage in the New York City survey of maternal deaths occasioned 7.5 per cent of the total.

In the Philadelphia survey, one death in every twenty-two, or five per cent, resulted from this cause.

In the fifteen States survey, 21 per cent of the 4134 women who died in the last trimester of pregnancy had post-partum hemorrhage as a primary or contributing factor. The reports of these three surveys state that it is a significant fact that a large proportion was regarded as preventable; and also, in the majority, mismanagement was considered the greatest cause.

The Health Department records of Newark for the past six years show a mortality rate of eight per cent. May it not be inferred by comparison that faulty management has been a factor with us?

Conceding these figures to be correct, we are forced to the conclusion that the mortality rate, which in a large measure is attributed to mismanagement of the third stage, is an inexcusable indictment of maternal welfare. This is another instance of the medical profession being on the defensive; another item for the bureaucrats to emphasize in their demands for adequate medical care, which is attracting widespread interest at the present time, and which we haughtily deny exists.

We should be profoundly impressed with the seriousness of this situation when conducting our deliveries. It demands of the profession, individual and organized, efforts at correction. The principles and procedures are

clearly set forth in all obstetrical text books. The obligation is imperative.

During pregnancy, our attitude demands that we protect mother and fetus by conscientious prenatal supervision, in order to avoid the dangers likely to ensue as a result of gestation.

During labor our efforts should be directed to the comfort and safety of the mother, and the delivery of a living baby. During the third stage, our vigilance must in no way be curtailed, until we are assured that the life and future health of the mother has been preserved. This can be accomplished only by a thorough understanding of the physiology, mechanism, and management along recognized

fundamental principles; and an ability to anticipate and meet pathological complications when they occur.

In closing, my first impulse is to apologize for discussing this subject from so elementary a standpoint; but on second thought I feel that, if an apology is forthcoming, it should be for my inability to give sufficient emphasis to its importance.

Perhaps we may be more deeply impressed with our moral responsibilities to these patients if we repeat with that immortal American, Dr. Oliver Wendell Holmes: "God forbid that any member of the profession to which she trusts her life, doubly precious at this eventful period, should hazard it negligently, inadvisedly or selfishly!"

686 Mt. Prospect Avenue

A LESSON FROM A DEATH CERTIFICATE

NUMBER FIFTEEN

Patient was said to have received adequate prenatal care. Entered hospital in labor at 2 a. m., with blood pressure of 204/124. Pains subsided and *patient was discharged* that evening. Why?

The following morning patient was readmitted with hemorrhage and in shock. Cesarean, following which patient promptly died.

A. W. BINGHAM, M.D.

BOOKS RECEIVED FOR REVIEW

Brucellosis in Man and Animals. By I. Forest Huddleson. Pp. 339. Price \$3.50. N. Y., The Commonwealth Fund. 1939.

Tumors of the Skin, Benign and Malignant. By Joseph Jordan Ellers. Pp. 607. Price \$10.00. Philadelphia, Lea & Febiger. 1939.

Manual for Diabetic Patients. By W. D. Sanson with Alfred E. Koehler and Ruth Bowden. Pp. 227. Price \$3.25. New York, Macmillan. 1939.

Tumors of the Hands and Feet. Edited by George T. Pack. Pp. 138. Price \$3.00. St. Louis, E. V. Mosby Co. 1939.

Injuries of the Nervous System: Including Poisonings. By Otto Marburg and Max Helfand. Pp. 213. Price \$3.00. New York, Veritas Press. 1939.

The Vitamins. A symposium arranged under the auspices of the Council on Pharmacy and Chemistry and the Council on Foods of the American Medical Association. Imitation leather. Price, \$1.50 postpaid. Pp. 637. Chicago: American Medical Association, 1939.

The Health Insurance Doctor—His Rôle in Great Britain, Denmark and France. By Barbara N. Armstrong. Pp. 258. Price \$3.00. Princeton, Princeton University Press. 1939.

STATE SOCIETY ACTIVITIES

CONFERENCE OF SECRETARIES AND EDITORS

The annual Conference of Secretaries and Editors of the Medical Societies of the several States was held in the building of the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, on Friday and Saturday, November 17 and 18, 1939, under the auspices of the American Medical Association. The Medical Society of New Jersey was represented by Dr. Alfred Stahl, Secretary of the Society; Dr. Frank Overton, Editor of The Journal; and Dr. Norman M. Scott, Executive Assistant, who was on the official program. The expenses of travel and hotel were borne by the American Medical Association, of which The Medical Society of New Jersey is a constituent part.

About 125 delegates were present from nearly every state and territorial society and the Hawaiian Islands. Many of the Editors and Secretaries had been regular attendants for twenty years or more, since they had held office in their State Societies for that length of time. It would be hard to visualize a conference without the presence of Holman Taylor of Texas, H. H. Shoulders of Tennessee, Frank Hammond and W. F. Donaldson of Pennsylvania, A. T. McCormack of Kentucky, and George H. Kress of California. Equally familiar were Dr. Olin West, Secretary of the A. M. A.; Dr. Morris Fishbein, Editor of the Journal of the A. M. A.; and W. C. Woodward, Director of the Legal Bureau of the A. M. A.

The meetings were characterized by friendliness and sociability, as might be expected from congenial physicians who annually come hundreds of miles to discuss medical problems of the most serious nature.

As has been the usual custom, a presiding officer was chosen from among the delegates,—Dr. Creighton Barker, Secretary of the Connecticut Medical Society, being elected.

THE PROGRAM

Three half-day sessions and one evening meeting were held, and were addressed by thirteen speakers, as follows:

FRIDAY MORNING

1. Greetings from the President of the A. M. A.,—Rock Sleyster.

2. Medical Care in the United States,—C. Ellsworth Nyberg, Bureau of Economics of the A. M. A.
3. The Wagner Health Bill,—W. C. Woodward, Director Bureau of Legal Medicine and Legislation of the A. M. A.
4. Present Horizons,—Austin A. Hayden, Secretary, Board of Trustees, A. M. A.

FRIDAY AFTERNOON

5. Medical Service Plans of State and County Societies—Introduction—Nathan B. Van Etten, President-Elect, A. M. A.
6. New Jersey Plan,—Norman M. Scott, Executive Assistant.
7. Michigan State Society Project,—L. Fernald Foster, Secretary.
8. Washington State Association Experience,—V. W. Spickard, Secretary.
9. Pennsylvania Plan,—W. F. Donaldson, Secretary.

FRIDAY EVENING

10. Dinner Meeting,—Carl B. Drake, Editor, Minnesota Medicine, presiding.
11. Editorials in Medical Journals,—Samuel J. Koptzky, Editor.

SATURDAY MORNING

12. Rural Medical Services,—F. S. Crockett, Committee on Legislation, A. M. A.
13. Legislative Problems,—Thomas A. Hendricks, Executive Secretary, Indiana State Medical Association.

OBJECTIVES

Discussion of vital problems rather than *decision*; and *education* rather than *propaganda*, were the methods which were observed by mutual consent. It was tacitly understood that the problems of administrative medicine varied widely in the several States, because of two fundamental conditions:

1. The nature of their needs.
2. The facilities for distributing medical services.

The discussions of the several plans that were presented were conducted with entire good nature, and with common realization of the complexities of the problems. While no State had developed a plan that was universally applicable, yet the members of the conference felt the seriousness of their duty to develop

a system to meet the greater needs of their communities. The realization of this responsibility was probably the most important effect of the conference and fully justified the effort and expense of holding it.

PRESIDENT SLEYSER

The address of welcome to the delegates was given by Dr. Rock Sleyser, President of the A. M. A. He described the headquarters of the A. M. A. as a home and a workshop to the great army of members of the A. M. A. He called attention to the great increase in the number of members of the A. M. A. during the last five years, and the opportunities and necessity of medical leadership at the present time.

SURVEYS OF MEDICAL CARE AND NEED

Dr. C. Ellsworth Nyberg, of the Bureau of Economics of the A. M. A., described the survey of medical care conducted by the several State Societies. He quoted the New Jersey report for its completeness and its informative qualities. He commended the Monroe County Medical Society, Tennessee, on the excellence of its report, although the society has only fifteen members.

WAGNER HEALTH BILL

The Wagner Health Bill was analyzed and described by W. C. Woodward, Director of Legal Medicine and Legislation of the A. M. A. He explained the features of the bill, both good and bad, and gave the history and background of its development.

PLATFORM OF THE A. M. A.

Dr. Morris Fishbein, Editor of the Journal of the A. M. A., described the platform of the A. M. A. which had been adopted by the Trustees on November 16. He distributed a four-page leaflet on the principles and said that they would be reproduced in each issue of the Journal. The essential point of the principles are as follows:

1. The establishment of a Federal agency for coördinating and administering the medical and health functions of the Federal government.
2. Federal funds to be allotted to the States for medical care on proof of the need of such assistance.
3. Medical service to the sick is primarily a local responsibility.
4. The local administration of means of relief belongs to the local units of government.
5. The medical care of the indigent belongs to the local administration.

6. The use of existing medical and hospital facilities is to be promoted.

7. The private practice of medicine is to be developed and fostered.

8. Public health services shall be expanded in accordance with the American system of democracy.

PRESENT HORIZONS

Dr. Austin A. Hayden, Secretary of the Board of Trustees of the A. M. A., urged the need for continuing the survey of medical services as a basis for a more complete system of practice.

Drs. West and Fishbein spoke of encouraging evidences of coöperation by the leaders of the Federal government with the medical profession.

Mr. C. S. Nelson, Secretary of the Ohio State Medical Society, said that the people of his state are asking what substitute the doctors will propose in place of the Wagner Bill. A law will be passed and the doctors should write it.

THE SECRETARIES AND EDITORS

Dr. N. B. Van Eetten, President-Elect of the A. M. A., emphasized the importance of the functions of the Secretary and the Editor of the State Society, and those of the county societies, for on them devolve the duty of informing the members of the decisions of the societies and thereby securing their support in carrying out the plans and projects of the organizations.

MEDICAL SERVICE PLAN OF NEW JERSEY

Dr. Norman M. Scott, Executive Assistant, The Medical Society of New Jersey, described the Medical Service Plan of New Jersey. The State Society recognizes two groups of the economically needy from a medical aspect:

1. The indigent,—those who are unable to pay for more than a small part of medical service, or to pay nothing at all.

2. The low-income group,—those who are able to pay for medical services, except in catastrophic illness.

Dr. Scott distributed a printed pamphlet outlining the New Jersey plan for the low-wage group, and its history.

THE MICHIGAN PLAN

Dr. L. Fernald Foster, Secretary of the Michigan State Medical Society, described the system of medical relief that had been developed by the State Medical Society of Michigan. An enabling Act had been passed by the Legislature to put the plan in operation.

Literature was distributed to the delegates describing the plan and its history.

THE WASHINGTON STATE SITUATION

Dr. V. W. Spickard, Secretary of the Washington State Medical Association, described the grave medical situation which arose because of economic conditions in the lumber camps and mills. He outlined the methods developed by the medical societies for the equitable distribution of medical care.

PENNSYLVANIA LEGISLATION

Dr. Walter F. Donaldson, Secretary of the Medical Society of Pennsylvania, described the difficulty of educating physicians regarding medical legislation, and the need of arousing their interest.

EDITORS' DINNER

In the evening a dinner of the Editors was held in the Palmer House, but all the Secretaries and other members of the conference also came, raising the number present to 125.

The after-dinner speaker was Dr. Samuel J. Kopetzky, who has for eighteen years been the Editor of *Medical Week*—the organ of the Medical Society of the County of New York. Dr. Kopetzky confined his remarks to "Editorials", and developed the philosophy that the editorial department of the journal is the repository of impersonal comment on medical principles that are adopted by the formal action of the society.

There was a lengthy discussion of the copyright law and the control of copying articles by other journals. The discussion included complaints that "throw away" journals pirate articles from the standard medical journals. The suggestion was made that physicians should write letters of protest to manufacturers who make extravagant claims for their product.

Altogether the dinner and the after-dinner speaking was one of the most practical and interesting features of the conference.

RURAL MEDICAL SERVICE

A detailed description of the various forms of rural medical service was given by F. S. Crockett of the Committee on Legislative Activities of the A. M. A.

LEGISLATIVE PROBLEMS

Thomas A. Hendricks, Executive Secretary of the Indiana State Medical Association, suggested that we abandon the term "Socialized Medicine", and substitute for it "Politicalized Medicine". He urged the medical societies to adopt tactics of offense, instead of the passive rôle of defending the old order.

QUALIFICATIONS FOR MEMBERSHIP

Dr. Alfred Stahl, Secretary of The Medical Society of New Jersey, inquired about the attitude of the A. M. A. toward osteopaths who apply for membership in the State Society. Dr. West enumerated some surprising examples of inconsistencies in regard to admissions of cultists to membership. He suggested that the societies provide a method of associate membership for those who are not licensed for the practice of all forms of medicine. The subject has many ramifications, and each applicant will have to be given individual attention.

SUMMARY

The members who have attended the annual A. M. A. conferences of State Secretaries and Editors year after year, expressed the opinion that this last conference was the most practical and profitable of all that they had attended. They also expressed the opinion that the acquaintances formed and the opportunities for private discussions and understandings were the most valuable features of the conference.

THE SECOND ANNUAL FALL CLINICAL CONFERENCE

By SAMUEL A. COSGROVE, M.D., Jersey City, N. J., General Chairman

I have the honor to report that the Second Annual Clinical Conference of The Medical Society of New Jersey was held in Hudson County, on November 9th and 10th, 1939.

Registration headquarters were established in the Jersey City Medical Center, and the work of registration was ably carried out under

the Committee on Reception, headed by Dr. Henry Spence, and aided by a number of the ladies of the Woman's Auxiliary.

The Committee on Transportation, under the chairmanship of Dr. Vincent J. Sheeran, provided bus and private car transportation to and from the point of registration to the dif-

ferent hospitals in the county. This work was also most helpfully participated in by the members of the Woman's Auxiliary.

PARTICIPATING HOSPITALS

A series of programs was arranged under the direction of a Program Committee, headed by Dr. Earl J. Halligan, and most loyally participated in by the members of the respective staffs of the following hospitals: Hudson County Tuberculosis Hospital, Margaret Hague Maternity Hospital, St. Mary's Hospital, Greenville Hospital, Jersey City Medical Center, North Hudson Hospital, Bayonne Hospital, Christ Hospital, Hudson County Hospital for Mental Diseases, and St. Francis Hospital.

The reception of visitors by the several hospitals was most kind, and all the participating hospitals provided luncheons for the visitors.

On each day papers and other items of a didactic and dry clinical program were presented at the Jersey City Medical Center by staff members representing the following hospitals: North Hudson Hospital, Greenville Hospital, Bayonne Hospital, Jersey City Medical Center, Hudson County Contagious Disease Hospital, St. Francis Hospital, Christ Hospital, St. Mary's Hospital, Hudson County Tuberculosis Hospital, Hudson County General Hospital, and Hudson County Hospital for Mental Diseases.

THE SOCIAL DINNER

On the evening of the second day, a combined dinner was held representing the Annual Dinner of the Hudson County Medical Society, and the Clinical Conference Dinner. Our own members and guests, to the number of 208, attended that dinner under the able chairmanship of Dr. George Ginsberg.

ATTENDANCE

The total attendance at the Conference was 383, of which 159 were from our own county; and the balance, 224, were from other counties throughout the State. In all, eighteen of the twenty-one counties in the State were represented by the attendance at the Conference, and there were visitors besides from New York, Massachusetts, and Philadelphia.

The local newspaper publicity was well looked after by a committee under the able leadership of Dr. Hugh H. Tyndall.

FINANCES

The cost of the Conference is chargeable against the allotment of \$800.00 set apart in the State Society budget for the expenses of this Conference. This allotment will more than cover the expense of the entire conference, and with no cost accruing to the Hudson County Medical Society.

In closing, I desire to express my own deepest appreciation of the fine interest and coöperation received in the planning and conduct of the Conference from Dr. James F. Norton, President of the Hudson County Medical Society, all the other officers and members of that Society who so unselfishly contributed their time, thought, and effort in making the Conference a success, which I believe it was; to the 40 per cent of the total membership of the society who in one way or another contributed to the several programs and presentations of the Conference; and to the directors and personnel of the several hospitals which took part therein.

Respectfully submitted,

SAMUEL A. COSGROVE, M.D.,
General Chairman,
Fall Clinical Conference.

PARTICIPATING INSTITUTIONS

The following hospitals of Hudson County participated in the Second Fall Clinical Conference of The Medical Society of New Jersey, September 9 and 10, 1939:

1. Bayonne Hospital, East 30th Street, Bayonne
2. Christ Hospital, 176 Palisade Avenue, Jersey City
3. Greenville Hospital, 1825 Hudson Boulevard, Jersey City
4. Hudson County Hospital for Mental Diseases, Secaucus
5. Hudson County Tuberculosis Hospital, Clifton Place, Jersey City
6. Jersey City Medical Center, Montgomery Street and Baldwin Avenue, Jersey City
7. Margaret Hague Maternity Hospital, Clifton Place, Jersey City
8. North Hudson Hospital, 658 Park Avenue, Weehawken
9. St. Francis Hospital, 25 East Hamilton Place, Jersey City
10. St. Mary's Hospital, Willow Avenue and Fourth Street, Hoboken
11. Contagious Disease Hospital

LECTURERS AND DEMONSTRATORS

The names of 165 members of the Hudson County Medical Society were listed as teachers or demonstrators. This was forty per cent of the membership of the society.

The following table lists the participating members; and the figure opposite each name indicates the doctor's hospital connection according to the list in the preceding paragraph:

	Hospital
Agolia, Michael W., Orthopedic Clinic	10
Alter, N. M., Ectopic Pregnancy, Hydatid Mole	7
Ash, A. F., Eye, Ear, Nose and Throat	2
Barrett, A. F., Surgery	9
Barone, L., Tryparsamide Therapy in Insanity	4
Barry, T. R., Toxemias of Pregnancy	7
Barry, T. A., Obstetric Pathology	7
Benjamin, Harold, Orthopedics	2, 6
Bigliani, V., Femur Fractures	9
Blakey, A. P., Anesthesia	9
Bortone, F., Surgery; Pneumolysis; Thoracoplasty	2, 5
Botti, J. A., Bronchoscopy	9
Braunstein, W. P., Pathology	10
Brick, G. J., Surgery	9
Brozdowski, J. J., Femur Fractures	9
Bruder, A. J., Femur Fractures	9
Burke, E., Traumatic Abdominal Surgery	6
Butler, V. P., Urology	6, 7, 9
Cannon, E., Sulphapyridine in Pneumonia	10
Catlaw, J. K., Surgery	9
Chayes, S., Surgery	1
Chesley, L. C., Toxemias of Pregnancy	7
Cohen, Samuel, Lung Abscess; Bronchiectasis	5, 6
Comora, H. C., Eye, Ear, Nose and Throat	2
Connell, E. J., Urological X-Rays	9
Connell, J., Blood Transfusions; Pelvic Measurements; Toxemias of Pregnancy	7, 9
Connolly, T. W., Tonsillectomy	9
Cosgrove, S. A., Inversion of Uterus; Obstetrics, ward rounds	7
Coughlin, J., Obstetric, Movies	9
D'Arcierno, P., Gynecology	8
Daly, Edmund J., Urology	6, 9
Davidoff, M., Metrazol Shock in Insanity	4
DeCecio, T., Thoracic Stomach; Tuberculosis Exhibits	5
DeFuccio, C. P., Intracranial Hemorrhage; Cooley's Anemia	7
DeFusco, Thomas, Obesity	6
Dilger, Frederick C., Orthopedic Clinic	10
Dolganos, Moses, Pathology, Medical Clinic	2
Donnelly, J. P., Postpartum Hemorrhage	7
Donohoe, L., Surgery	1
Doran, W. J., Bacteriophage for Osteomyelitis	6
Duckett, W. J., Eye, Ear, Nose and Throat	2
Elwood, B. J., Pick's Disease (Parapulmonary Tuberculosis)	5
Enright, J. G., Pathology, Medical	2
Faison, John, Neoplastic demonstrations; Malignant Diseases; X-Ray Treatment	6, 9, 12
Fellman, Morris, Hyperthyroidism	6
Fineberg, J., Diabetes	6
Fort, J. Irving, Regional Fracture Committee	
Frank, Nathan, Vascular Diseases, Peripheral	6
Garbaldi, L. J., Medical Clinic	9
Ginsberg, George, Sulfapyridine in Pneumonia —Protamine Zinc Insulin	2, 10
Gitlitz, F. J., Gastric Ulcer, Lantern Slides and Conference	2
Gleason, T. P., Surgery	9
Gnassi, Angelo, Pathology	6
Good, C. K., Dermatoses	9
Gorenberg, H., Heart Disease in Pregnancy	7
Green, Albert, Pathology, Medical	2
Greenville Hospital Staff, Clinical Conference	3
Grewal, J. S., Surgical Pathology	1
Grieco, E., Cardiac Cases	1
Hall, P. O., Vomiting of Pregnancy	7
Halligan, E. J., Surgery	9
Halligan, H. J., Surgery	9
Hart, Arthur, X-Ray	6
Harvey, J. W., Medical Ward Rounds	1
Heilbrunn, J., Pediatrics	2, 7
Hekeian, J. H., Urology	2
Herradora, J. R., Tuberculosis Therapy Methods	9
Imhoff, J. G., Surgery	9
Jaffe, H., Surgery	3
Jaffin, A. E., Tuberculosis Clinic; Thyrotoxicosis	5, 6
Judy, Kenneth, Surgical	6
Justin, Arthur W., Medicine	8
Kelley, Charles B., Gynecology Clinic	6
Kelly, H. J., Sulfapyridine in Pneumonia	10
Kerdasha, George S., Pediatric Clinic	8
Klaus, Henry	2
Kraut, A. M., Neurology	2
Kuhlmann, A. E., Fractures	8
Landshof, Charles	6
Lange, L. C., Surgery, Gastric Ulcer Conference	2
Larkey, C. J., X-Ray Clinic	1
Lefkowitz, J. H., Pediatrics	2
Lemmerz, T., Eye, Ear, Nose and Throat	2
Lepis, A. A., Femur Fractures	9
Levine, H., Paresis	4
Lindroth, L. V., Surgery	2
Londrigan, J. F., Surgery	10
Luppold, E. J., Pathology, Medical Clinic	2
Lynch, R. J., Foreign Bodies Swallowed by the Insane; Movie on Metrazol Shock Treatment of Insanity	4
Macchia, E. J., Myxedema Heart	9
Mackin, J. J., Pain, Left Arm	9
Magner, J. P., Surgery	9
Maras, Peter, Occupational Dermatoses	3
Markowitz, B., Eye, Ear, Nose and Throat	2
Markowitz, I., Urology	2
Masiello, C., Metrazol Shock in Insanity	4
Mathews, W., Surgery	10
Maver, W. W., X-Ray; Kymography	2, 9
McLean, H., Surgery	10
McLoughlin, F. J., Surgery	9
Mickewich, S. A., Blood Transfusions; Gangrene of Arm	9
Moriarty, J. F., Femur Fractures	9
Murphy, E. A., Eye, Ear, Nose and Throat	2
Natrass, R. B., Pathology, Medical, Clinic	2
Nicolson, F. P., Eye, Foreign Bodies in	9

Norton, J. F., Hemorrhagic Complication of Late Pregnancy; Obstetrics, movies; ward rounds	7, 9	Schuchner, W. F., Varicose Veins	9
Oderr, C., X-Ray; Kymograph and cases	2, 9	Schuck, T. J., Surgery	10
O'Grady, Benson J., X-Ray Exhibit	10	Sciorsci, E. F., Surgery; Conization of Cervix ..	9
Ohio Chemical Co., Apparatus for Resuscitation of the Newborn	7	Scott, J. J., Metrazol Shock in Insanity	4
Olpp, A. E., Surgery	5	Selinger, Samuel, Eye, Ear, Nose and Throat ..	2
Pagliughi, John J., Atelectasis; Bronchoscopy ..	8	Sheeran, V. J., Surgery	9
Pearlstein, F., Cardio-vascular Disease	6	Shulman, B., Malarial Therapy in Paresis	2, 4
Perkel, L., Peptic Ulcer	6	Siegel, L., Malarial Therapy in Paresis	4
Perlberg, H. J., Pelvic X-Rays	6, 7	Sirken, Charles, Pathology, Medical Clinic	2
Peters, E. A. P., Surgery	3	Smith, A. L., Eye, Ear, Nose and Throat	2
Piltz, G., Coronary Disease	6	Sprague, Seth B., Orthopedics	2, 6
Potter, B. P., Tuberculosis, Modern, Management of	5	Stockfish, R., Avitaminosis	3
Povalski, A., Anesthesia	9	Stout, J. P., Pediatrics	2, 7
Pyle, Wallace, Eye, Ear, Nose and Throat	2	Stout, P. G., Pediatrics	7
Quinn, J. J., Surgery	2	Straatsma, C. R., Skin Diseases and Grafting, talking movies	6
Read, J. D., Placenta, Abruptio of	7	Street, Daniel, Pericarditis	6
Reznikoff, L., Insulin Shock in Insanity; Optic Nerve Atrophy in General Paresis	4	Sullivan, James, Feeding the Newborn	7
Roberts, E. W., Surgery	2	Thomas, R. D., Eye, Ear, Nose and Throat ...	2
Rose, S. J., Endocrines; Pathology	9	Tidwell, H., The Premature Baby	7
Rosenstein, J. L., Eye, Ear, Nose and Throat ..	2	Tomaioli, M. F., Surgery	2
Rundlett, Emile, Contagion	6	Tyndall, H. H., Surgery	2, 10
Ruvane, J. J., Low-Back Pain	9	Ulvestad, L., Proctoscopic Clinic	6
Sacco, A. C., Bronchiectasis and Bronchography ..	5	Visconti, J., Surgery	10
Salmon, E., Sulphanilamide in Scarlet Fever, Erysipelas, and Meningitis	11	Walscheid, A. J., Gynecology Clinic	8
Sandler, Samuel A., Neurology	2	Ward, Leo, Regional Ileitis	3
Schulman, A. S., Surgery; Puerperal Sepsis ...	7	Waters, E. G., Surgery; Maternity Ward rounds; Cesarean Operation in Color Movies ..	2, 7
School, The A. Harry Moore for Crippled Children		Weber, W. L., Pathology, Medical Clinic	2
		Weiss, A., Placenta Previa	7
		White, Thomas, Myxedema Heart; Multiple Myeloma	6, 9
		Woodruff, S., Urology	1
		Yeaton, William, Surgery	2

ANNUAL CONFERENCE OF COUNTY SOCIETY OFFICERS

A conference of officers of county medical societies was held on Sunday, November 26, 1939, in the Roof Garden of the Stacy-Trent Hotel, Trenton, N. J., with about forty present. A social luncheon was served at one o'clock, after which the conference was held while the physicians were at the tables.

President E. Zeh Hawkes, who conducted the meeting, in his opening remarks announced that the meeting had been authorized by the Trustees for the benefit of the county societies, in order that their representatives might help one another and themselves by discussing mutual problems of objectives and procedures. County medical societies differ fundamentally in tradition and opportunity, and also because of the changing personnel of the leaders from year to year.

The meeting lasted over two hours, with not a dull moment. The speakers had prepared their points with care, and delivered them in brief sentences, which were effective in their

brevity and conciseness. The mimeographed program was as follows:

Presiding officer, Dr. E. Zeh Hawkes, President, The Medical Society of New Jersey.

Welcome,—5 minutes—Dr. Ralph K. Hollinshed, Chairman, Board of Trustees.

How to preside at a meeting,—10 minutes—Dr. Hilton S. Read, Chairman, the Welfare Committee.

Membership in a county society,—10 minutes—Dr. William J. Carrington, Fellow.

Duties of a President of a County Society,—10 minutes—Dr. Royal A. Schaaf, President, the Essex County Medical Society.

How to make the yearly program of a county society interesting,—10 minutes—Dr. George J. Young, Secretary, the Morris County Medical Society.

What a Secretary can do to help his county society,—10 minutes—Dr. Chester I. Ulmer, Secretary, the Gloucester County Medical Society.

The duties of a Reporter,—5 minutes—Dr. Paul Hosp, Reporter, the Essex County Medical Society. Discussor,—5 minutes—Dr. Frank Overton, Editor, The Journal of The Medical Society of New Jersey.

Duties of the Executive Committee of a county society,—10 minutes—Dr. J. Lawrence Evans, Censor, Executive Committee, Hudson County Medical Society.

Full stenographic notes of each address and discussion were taken, and President Hawks expressed the hope that they might be a basis for a manual of uniform methods of procedure by the county societies. Only a brief outline of the addresses will be given in this report of the proceedings.

UNIFORMITY OF METHODS

Dr. Hollinshed, in his concise remarks, referred to the series of meetings of the several committees of the State Society, whose proceedings were published in the annual reports and in their progress reports which had appeared in *The Journal* throughout the year. He expressed his confidence that the uniform methods adopted by the committees would be precedents to encourage the county societies to adopt similar methods of developing their programs.

CONSTRUCTIVE CRITICISM

Past President Carrington gave a most practical address on the opportunities of county societies in preventing their members from becoming introverts, and expressed the hope that their zeal for criticism might be put into the form of *constructive planning*.

Dr. Carrington referred to the great variance in the details of the by-laws of the several county societies, and stressed the importance of first adopting a practical set, and then living up to them. He also brought out the desirability of incorporating each county society in order to relieve the members of liability for their individual actions done in the name of the Society.

THE PRESIDING OFFICER

Dr. Hilton S. Read, Chairman of the Welfare Committee, compared the presiding officer of a county society to a leader of a symphony orchestra, and the members to the performers. Among the practical suggestions which Dr. Read offered (and which he has exemplified in the meetings of the Welfare Committee) were:

1. Have a definite program for each meeting, and a definite amount of time assigned to each subject.
2. All committee reports to be in writing with a time limit for their consideration.
3. Open each meeting on time, and introduce the principal speaker at the hour which is announced on the program; and be sure to state his name and position correctly.

4. After each meeting, write a personal note of appreciation to the guest speaker.

The wealth of practical suggestions offered by Dr. Read will make a most interesting chapter in the proposed manual.

AN EXECUTIVE COMMITTEE

Dr. Royal Schaaf, President of the Essex County Medical Society,—the largest local unit in the State,—suggested that each society have a *planning committee*—an executive committee—which should consider the details of the business affairs and general plans of the Society, and report them to the meeting in brief form. This committee would function in a manner similar to the reference committees of the House of Delegates, which is a willing listener to the arguments on disputed points and complaints, and presents the summaries to the general meeting.

The principal suggestions of Dr. Schaaf will apply to every county society, be it large or small.

Dr. Schaaf strongly approved the plan that each county society should have a president-elect, so that he would have a year of preparation for his duties as president.

In the discussion of Dr. Schaaf's remarks, several speakers suggested that the year of administration of each county society should coincide with that of the State Society.

THE PRESIDENT OF THE SOCIETY

Dr. George J. Young, Secretary of the Morris County Medical Society, suggested practical means for making the meetings of county societies both practical and interesting, with due consideration for the tastes of the individual members. He described some of the methods followed by the Morris County Society, some of the meetings being social in their nature, others devoted to travelogues and distinguished speakers, and some strictly scientific,—but the methods are changed before they become tiresome or commonplace.

Dr. Young suggested that the principal part of the routine business of the Society be transacted by the Executive Committee, and the conclusions published in the *Bulletin* of the Society.

For committee meetings, the Morris County Medical Society had adopted the plan of having a bottle, and sandwiches on the tables as an efficient means of promoting harmony and facilitating the transaction of business. Dr. Young also referred to the value of light refreshments served after each meeting.

In the discussion, several speakers referred to the importance of a social hour after the close of each meeting.

THE SECRETARY

Dr. Chester I. Ulmer, Secretary of the Gloucester County Medical Society, outlined the opportunities of the Secretary in making the meetings interesting, and said that though the President is changed each year, a good secretary should be kept in office year after year. Among the points of a good secretary, Dr. Ulmer enumerated:

1. Be the first member to appear in the meeting room, and the last to leave.
2. Have the minutes typed for easy reading.
3. Be the confidential aid to the president.
4. Supply practical subjects for the bulletin of the society.

In the discussion, Dr. Knowles, President of the Bergen County Medical Society, mentioned the importance of preserving the minutes in a place that is both safe and accessible, for few societies have preserved their old minutes.

THE REPORTER

Dr. Paul Hosp, Reporter for the Essex County Medical Society, spoke on the value of the work of the reporter, especially in sending reports of the meetings of the society to The Journal, and including the reports of allied organizations, such as those of the Academy of Medicine, and hospital staffs, to be published in The Journal of the State Society. A monthly outline of the proceedings of each county society is of great value to other county societies and their officers and committeemen.

In the discussion Dr. Overton, Editor of The Journal, referred to the importance of the special department devoted to county societies, and the value of the reports as sources of information and inspiration to the members of other county societies. Every item of information is of importance, including items stating that certain subjects were discussed although no decision had been reached.

The Editor stated that the duties of a reporter are similar to those of a local reporter of a metropolitan newspaper, which uses every item of importance even though the available

space may require that it be condensed to a few lines. As a matter of fact, The Journal Editor spends more time on the department of county society reports than on any other department. Moreover, the index of the county society reports is as long as that of any other department of The Journal. The department of county society reports is one of the features which is of the most practical importance and value to the members.

THE EXECUTIVE COMMITTEE

The importance of the duties of the Executive Committee of a county society was emphasized by Dr. J. Lawrence Evans, Censor, member of the Executive Committee of the Hudson County Medical Society.

The Executive Committee acts in the interim between the meetings of the society, and performs duties similar to those of the Trustees of the State Society. It fills vacancies among the officers and committees.

The Executive Committee of the Hudson County Society invites the officers and the chairmen of committees to its meetings, and hears discussions on controversial subjects, thereby affording every member an opportunity to express his views, without taking up the time of the society's meetings. As an example of the need of an active Executive Committee Dr. Evans cited an instance when the Society engaged in a discussion lasting until eleven o'clock, and then discovered that the guest speaker had gone home.

SUMMARY

The last speaker was Dr. Wilkes, Executive Officer, who briefly reviewed the more practical suggestions of the several speakers. He especially commended the preparation of a manual which should contain the suggestions of the several speakers in available form. The special value of the manual would be that its contents would consist of the spontaneous suggestions emanating from the county societies themselves.

ADVISORY COMMITTEE ON HOSPITAL RELATIONSHIPS

A joint meeting of the Advisory Committee on Hospital Relationships with representatives of the New Jersey Hospital Association, and the New Jersey Dental Society, was held on Sunday, November 12th, 1939, at 11 a. m., at the Executive Offices, Trenton, N. J. Those present were:

- Dr. S. T. Snedecor, Chairman of the Hospital Relationships Committee, who presided.
- Dr. Thomas K. Lewis, Consultant from the Board of Trustees.
- Dr. H. B. Decker, Vice-Chairman of Hospital Relationships Committee.
- Dr. E. H. Snively, member of Hospital Relationships Committee.
- Dr. E. Zeh Hawkes, President of The Medical Society of New Jersey.
- Mrs. M. S. Conklin, President of The New Jersey Hospital Association.
- Dr. George O'Hanlon, Secretary of The New Jersey Hospital Association.
- Dr. Frank J. Houghton, representing The New Jersey State Dental Society.
- Mr. L. A. Ayer, Superintendent of the Cooper Hospital, Camden.
- Dr. Norman M. Scott, Executive Assistant, The Medical Society of New Jersey.

Dr. Snedecor explained that the purposes of the meeting were as follows:

1. To promote a coöperative effort with The New Jersey Hospital Association, to determine what problems that Association is particularly interested in; and in the solution of which they felt the assistance of The Medical Society of New Jersey would be of value.
2. To carry out in conjunction with the Hospital Association some of the provisions of the survey of the New Jersey hospitals made by the Hospital Relationships Committee, and completed last year.
3. To develop a sample constitution and by-laws to govern the organization, function, promotion system, and relative position of the professional staff in the hospital organization of New Jersey hospitals.
4. To consider a list of topics of mutual interest for the combined study of the members of the professional staffs, hospital administrators, and Trustees.

From the committee report of October 19th, 1939, paragraph four is quoted. This paragraph lists topics suggested by the committee at that meeting.

"4. That the governing boards of hospitals in New Jersey be acquainted with certain problems common to the administrative staffs, professional staffs, and governing boards; and that these governing boards be asked to consider

the problems submitted to them; thus assisting in the solution of these problems. These problems are to be limited to the problems which should be particularly considered by governing boards. Among these problems might be:

"a. The question of auxiliary service fees, such as those charged for laboratory and x-ray work.

"b. The possible readjustment of private room and ward rates; and a study of the actual cost per day per patient for ward and private room care.

"c. Consideration of the possibility of increasing accommodations for private patients of moderate circumstances as ward patients, at a moderate cost for hospitalization, and reduced fees to the attending physicians.

"d. That each member of the governing board consider the efficiency of the socio-economic investigation in their respective hospital, and take steps to assure proper socio-economic investigation of each patient attending the clinics, or admitted to the hospital for care.

"e. That governing boards consider the per diem rates charged Workmen's Compensation cases, to assure that sufficient charge for hospital care is made to cover cost of that hospital care, and that this cost be up to \$5.00 a day per patient if this amount is necessary to defray the actual cost.

"f. That the governing boards consider the possibility of permitting attending physicians to make charges for their service in the care of all compensation cases admitted to the hospitals.

"g. That the governing boards consider the problem of accident cases admitted to the hospitals, to assure that each case has a proper socio-economic investigation to determine the economic status of the patient and his ability to pay for private care.

"h. That the governing boards of hospitals give instructions, that all bills submitted to patients by the hospital for hospital care state on the bill that the amount is for hospital service only, and not for the payment of professional services rendered by physicians; that instances where there are exceptions to this, the exception be so stated."

Mrs. Conklin stated two subjects which she felt were of particular concern at present:

1. Interne problem.
2. Pneumonia serum problem.

INTERNE PROBLEM

The interne problem was discussed. It was brought out that the action of the Board of

Medical Examiners had been determined upon the basis of an interpretation by the Attorney General; that a special committee was to meet November 13th, 1939, to discuss the problem with the Attorney General. It was the opinion of the Hospital Relationships Committee that this subject being under consideration of a special committee, was not an immediate concern of this committee, and that this committee had nothing constructive to offer at this time.

PNEUMONIA SERUM PROBLEM

This problem was discussed by Dr. Lewis from a standpoint of the opinion of the Pneumonia Committee of this Society. It is the opinion of the Pneumonia Committee:

1. That the distribution of serum should be continued.
2. That proper appropriations should be made by the Legislature for the purchase of serum.
3. That the more common types of serums should be supplied to all stations.
4. That the less common types of serums be stocked in Trenton.

Those present requested that the Hospital Relationships Committee take steps, in cooperation with the President of The Medical Society of New Jersey to bring attention to the Board of Health, Legislators, State Legislative Committee Chairman, the recommendations of the Pneumonia Control Committee in order to impress all concerned with the importance of making proper provisions for the purchase and distribution of pneumonia serum as was done last year. This decision was reached after consideration of the value of the newer remedial agencies now being used in the treatment of pneumonia. The Pneumonia Com-

mittee feels that there is still a wide field of usefulness for pneumonia serum.

PROMOTING INTEREST

The Hospital Relationships Committee discussed the problem of how greater interest of hospital governing boards can be aroused. They felt it is important that the governing boards be impressed with the fact that the professional staffs have a broader interest in the affairs of hospitals than just the purely technical subjects pertaining to medicine. The committee feels that in many hospitals many individual members of the governing boards do not take sufficient active interest in the problems of the hospital and staff members; this being manifested by small attendance of governing board members at the meetings of hospital administrators, and meetings of hospital staffs.

MODEL FORM OF BY-LAWS

The committee agreed to develop sample forms of constitution and by-laws to govern the duties and positions of the professional hospital staffs. The structure of a basic constitution and by-laws which would be common to all hospital staffs and altered in detail to suit the particular problems of the individual hospitals was discussed, and provisions were made for a further detailed study of the subject.

The committee adjourned at 1:00 p. m. The next meeting will be held at such time as there is something definite to present to the committee regarding the construction of a constitution and by-laws for hospital staffs. This, it is hoped, will be in the near future.

NORMAN M. SCOTT, M.D.,

Executive Assistant.

DIPHTHERIA IMMUNIZATION

On page 591 of the October issue of the Journal, containing an article on "Standards of Immunization Against Diphtheria", by Dr. L. Charles Rosenberg, Newark, published by the Child Health Committee, there was a typographical error in the first paragraph defining the three most commonly used antigens in diphtheria immunization, in that the sentences describing these agents were interchanged. The text should read:

"In order to induce active immunity, three antigenic materials are available:

- "1. Toxin-antitoxin, which consists of a

mixture of diphtheria toxin and antitoxin with a very slight excess of the latter.

"2. Toxoid is prepared by destruction of the toxic part of the diphtheria toxin molecule with formalin, leaving the immunizing portion free for antigenic activity.

"3. In the case of alum precipitated toxoid the loss of toxicity and purification is accomplished through precipitation by means of a two per cent solution of alum."

This corrected text will appear in the reprints.

NEW JERSEY HEALTH AND SANITARY ASSOCIATION

The sixty-fifth annual meeting of the New Jersey Health and Sanitary Association was held in the Berkeley-Carteret Hotel, Asbury Park, N. J., on Friday and Saturday, November 17 and 18, 1939. The programs were as follows:

FRIDAY, 10:30 A. M.—SANITATION

The *Section on Sanitation* met, with Mr. L. VanD. Chandler, Second Vice-President, presiding.

1. A Panel Discussion was held with speakers: H. P. Croft, Chairman of the Committee; S. A. Kowalchik, State Department of Health; R. C. Erickson, Health Officer, Long Branch; C. K. Blanchard, State Department of Health; M. W. Cowles, Health Officer, Hackensack Water Co.

2. Address, "The Relation of Mosquitoes to Encephalomyelitis", F. C. Bishopp, Ph.D., U. S. Department of Agriculture.

3. "Streptococci of Bovine Mastitis", Dr. Ralph B. Little, Rockefeller Institute for Medical Research. A bacteriological exhibit was shown.

FRIDAY, 10:30 A. M.—PUBLIC HEALTH

Also at 10:30 a. m., a *Section on Public Health Nursing* was held, with Dr. J. R. Morrow, President, New Jersey Health and Sanitary Association, presiding:

1. "Public Health Nursing", Nellie Ogilvie, R.N., Chairman of the Committee.
2. "Mental Diseases", Joseph E. Raycroft, M.D., Chairman of the Committee.
3. "Public Health Nursing with Social Security Funds", Hortense Hilbert, R.N., Field Consultant, Children's Bureau.
4. "Nursing in the Medical Care of the Indigent", Mary D. Forbes, R.N., Regional Consultant, U. S. Public Health Service.

FRIDAY, 12:15 P. M.

Friday, 12:15 p. m. A private luncheon meeting of *Health Officials*, F. J. Osborne, President.

Friday, 12:15 p. m. *New Jersey Social Hygiene Association* luncheon meeting, Jacob A. Goldberg, discussion leader.

FRIDAY, 2 P. M.—INDUSTRIAL HEALTH

New Jersey Health and Sanitary Association.

1. "Industrial Diseases", L. D. Bristol, Vice-President.
2. "Health Problems of the Smaller Industries", Donald M. Shafer, National Association of Manufacturers.
3. "Objectives of the State Medical Society in the Field of Industrial Health", J. Irving Fort, M.D., Chairman of the Committee.
4. "Program of Syphilis Control in Industry", Karl M. Scott, M.D., State Department of Health.

FRIDAY, 2 P. M.—NEW JERSEY HEALTH AND WELFARE CONFERENCE

1. "The Expansion of Public Health", Mr. William H. MacDonald, State Department of Health, Vice-Chairman of Committee.

- a. "Child and Maternal Health", Julius Levy, M.D.

- b. "Crippled Children", Joseph G. Buch, Chairman of the Commission.

- c. "Pneumonia", Joseph V. Craster, M.D., Health Officer, Newark.

- d. "Cancer", Joseph H. Kler, M.D.

- e. "Local Health Administration", F. J. Osborne, Health Officer, East Orange.

2. "State Public Health Administration", J. Lynn Mahaffey, M.D., Director of Health.

3. "Hospital Facilities", Edward Guion, M.D., Chairman of the Committee and Emil Frankel, Ph.D., State Department of Health.

4. "Medical Care of the Indigent", Spencer T. Snedecor, M.D., Hackensack, Chairman of the Committee, and Frederick P. Lee, M.D., Paterson.

FRIDAY, 5 P. M.—MOVING PICTURES

1. "With These Weapons"—Syphilis.
2. "If It's Health You're Seeking."
3. "On the Firing Line"—Tuberculosis.
4. "Why Let Them Die." Talking slide film from N. J. Birth Control League.
5. "The Nurse's Responsibility in Sight Saving." Talking slide film from the National Society for Prevention of Blindness.

FRIDAY—ALL-DAY EXHIBITS

1. Bacteriological Exhibit, Dr. Ralph B. Little, Rockefeller Institute for Medical Research, Princeton.
2. Syphilis Diagnosis Exhibit, A. J. Casselman, M.D., State Department of Health.
3. Publicity Helps from State and National Organizations.

FRIDAY, 8 P. M.—SIXTY-FIFTH ANNIVERSARY SESSION

1. Invocation, Rev. Otto L. F. Mohn, Asbury Park.
2. "Public Health of Tomorrow", Joseph R. Morrow, M.D., President of the Association, Ridgewood.
3. "Accomplishments and Plans of the Health and Welfare Conference", Robert Clothier, L.L.D., President Rutgers University, and General Chairman of the Conference.
4. "Medical Progress and Social Progress", Howard W. Haggard, M.D., Director, Laboratory of Applied Physiology, Yale University.

SATURDAY, 10 A. M.

Annual Meeting *New Jersey Health and Sanitary Association*, Joseph R. Morrow, M.D., President.

1. "Progress in New Jersey Birth Control", Mrs. Robert Ilsley, President, New Jersey Birth Control League.

2. "Prenatal Tests for Syphilis", John Hall, State Department of Health.

TREASURES OF THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

The story of Medicine is not just a collection of facts, accumulated through the centuries, and then deposited in ponderous tomes to gather dust in musty libraries. No, indeed! There is nothing more vital or more inspiring than the perusal of books dealing with the recording of medical thought as it searches for truth through the years. In all of these can be perceived the tenacious groping for the best means of preserving the most wonderful mechanism on earth.

Civilizations may come and go; wars, famines, pestilences, and other disasters may visit the human race from time to time. Through all this, Medicine has never changed or wavered in its primary purpose. As waves of destruction came and went, the medical men were always occupied with but a single purpose,—the repair of human wreckage, and the prevention of the sinister visitors such as plague, smallpox, yellow fever, malaria, and many others, from returning; or at least to devise a means for their control. Like beacons in impenetrable darkness, isolated geniuses of past generations stood out throughout history, keeping up the light of progress, and through their work and

suffering giving incentive to the medical men of the future. They left their priceless heritage of thought and research safely stored in great libraries of the civilized world for posterity to read. It ill behooves us to laugh at some of their observations and conclusions. Remember that the future may laugh at us. Yet, in their time, their theories and deductions were the order of the day, and though many of them were erroneous, they left some vestige of scientific truth to fire the imagination of generations to come.

The task of preserving such works, therefore, brings its own reward. Never have I handled a single volume of an author long dead, but that a sense of profound reverence would come over me as I diligently repaired the yellowed and warped pages of the child of his brain, now stilled. Our Academy rightfully boasts of many such volumes. For my part, I sincerely hope to be able to continue this labor of love for many years, and watch our priceless collection grow into enviable proportions.

AARON E. PARSONNET, M.D.

THE NORTHERN NEW JERSEY DERMATOLOGICAL SOCIETY

C. C. Carpenter, M.D., Summit, N. J., Secretary

The Northern New Jersey Dermatological Society began its fifth yearly series of conferences on Wednesday evening, October 18th, 1939. This meeting was held in the auditorium of the Academy of Medicine, Lincoln Park, Newark, N. J., and was attended by twenty of the thirty-six members enrolled. The President, Dr. Louis J. B. LeBel, of Nutley, was in the chair.

The following cases were presented for inspection and discussion:

1. Pityriasis Rosea, by Dr. F. J. McCauley, Newark. This was a white woman, aged fifty-five, with extensive pruritis maculor lesions on the trunk, arms and thighs with intense itching. It was decided that this was a self-limited condition, and would be helped by various forms of mild peeling treatment.

2. Tuberculosis Cutis, by Dr. N. B. Heller, Newark. A white man, twenty-nine years old, for three years has had an erythematous and swollen nose, with nodules and scaling; and a similar condition on the left knee. Tuberculin test was positive. The case improved under a high caloric diet, cod-liver oil, Alpine lamp and unfiltered x-rays, and five per cent ammoniated ointment.

3. Lichen Plasms, by Dr. N. B. Heller, Newark.

4. Lupus Vulgaris, by Dr. R. H. Salsberg, Newark. A white woman, aged sixty, with an atrophic eroded area on the front of the neck. This case was presented for diagnosis, since it might be malignant.

5. Lupus Erythematosus, by Dr. M. Saffron, Passaic. A white man, aged fifty-seven, with scaly macules on one side of the face. The treatment suggested was gold salts intravenously, and bismuth intramuscularly.

6. Mycosis Fungoides, by Dr. N. B. Heller, Newark. A white man, aged forty, for ten years has had a scattered follicular eruption over the entire body. A biopsy was suggestive of mycosis fungoides.

There was a report of a meeting of dermatologists held in Haddon Hall on June 7th, during the Annual Meeting of the State Society. This meeting decided to petition the Trustees to form a Section on Dermatology and Syphilology in The Medical Society of New Jersey. Already a petition for this purpose has been signed by twenty-three members. On motion it was decided to present the petition to the Board of Trustees.

MILITARY SURGEONS ASSOCIATION

A symposium on how well prepared are the medical services of the armed forces for meeting an emergency was held by the New Jersey Chapter of the Association of Military Surgeons at the Academy of Medicine, Newark, on October 26. Professor W. Harry Snyder of the Montclair State Teachers College talked on the advantages which should come from the present coöperative spirit of the republics of North and South America. The changing scenes in Europe and their effect upon the United States was part of the discussion by Professor Snyder.

Lieutenant-Colonel Welton M. Modisette, of the Third Military Area Headquarters, told of the organization of the Army, particularly as regards its reserve sections, to meet any emergency. He called attention to the necessity of every Medical Department Reserve officers being properly assigned in time of peace so that in the event of war the as-

signment may not result in "trying to fit a square plug in a round hole".

Colonel Frank W. Weed, Second Corps Area Surgeon, told of the work which has been done to make the Medical Department of the Army an effective arm of the service ready for any emergency.

Captain Edward H. H. Old, Medical Director of the Third Naval District, explained the set-up of the Naval medical forces and of the aim to make every Navy doctor equipped for any assignment—on sea or on land.

Physicians holding commissions in the Army or Navy Reserves or in the National Guard, and medical veterans are invited to all Chapter meetings. The next meeting will be held in December. Information concerning meetings may be had from the Chapter Secretary, Major Edward A. Wickham, Roche Park, Nutley, N. J.

BLOOD DONOR'S CLINIC

A blood donors' clinic was held recently at Bergen Pines, Bergen County Hospital, in Ridgewood, N. J. Approximately thirty-six former poliomyelitis patients donated blood, from which convalescent serum will be made. The work was performed by the Medical and Laboratory Staffs at Bergen Pines, under the personal supervision of Dr. A. J. Casselman of the New Jersey State Department of Health. Through the coöperation of Dr. J. Lynn Mahaffey, Director of the State Department of Health, and Mr. William H. MacDonald, Director of the Bureau of Local Health Administration of the same department, Dr. Casselman was present during the entire procedure.

Arrangements were made through Dr. Anderson and Dr. Leonard of Squibbs to have the blood processed by E. R. Squibb and Sons Laboratory, and their very splendid coöperation was greatly appreciated.

The polio convalescent serum will be stored in 20 cc. vials, and will be available at Bergen Pines for therapeutic use for patients admitted there, and also can be secured by the practicing physicians of the county for their private poliomyelitis patients.

JOSEPH R. MORROW,

Medical Director and Superintendent.

AMERICAN HOSPITAL ASSOCIATION

At the opening session of the forty-first annual convention of the American Hospital Association in Toronto, Dr. Joseph R. Morrow, Medical Director and Superintendent of Bergen Pines, Bergen County, presented to the Association a life-sized bust of Florence Nightingale, which was constructed in the Occupational Therapy Department of Bergen County Hospital. The gift was accepted by Dr. G. Harvey Agnew, President, and will stand in the

foyer near the archway into the new American Hospital Association library in Chicago.

At the Nursing Section of the Convention, Dr. Morrow delivered an address on "The Prevention of Communicable Diseases Among Nurses in General Hospitals". The address was followed by a short film in technicolor, showing the aseptic nursing technic practiced at Bergen County Hospital. The hospital personnel did the preliminary work and filming,—adapting the therapeutic pool solarium as a location for the various sets.

At the annual meeting of the American Academy of Pediatrics at Cincinnati, Ohio, last week, Dr. Stanley Nichols, Chairman of the Child Health

Committee, was honored by reelection to the chairmanship of Region One of the Academy, for a term of four years.

OBITUARIES

DR. FREDERICK A. KINCH

Dr. Frederick Adrian Kinch, of 267 Broad Street, Westfield, President of the Board of Health, and Town Physician for nine years, died on October 25 at his home after a short illness. Dr. Kinch, who was seventy-nine, was born and had lived all his life in the same house.

Dr. Kinch's father, Dr. Frederick A. Kinch, Sr., had established a practice in the same house in 1849 and continued until his death in the late 1890's. His son, in turn, had joined his father in 1881 and carried on the practice since.

Dr. Kinch was honored April 30 last by the Westfield Medical Society at a dinner in celebration of his fifty-seventh anniversary as a practicing physician. He was graduated from the College of Physicians and Surgeons at Columbia University fifty-eight years ago, and was Past President of the Medical Society, which he had founded. He also was a Past President of the Union County Medical Society.

Dr. Kinch was a thirty-second-degree Mason and a Knight Templar. He was a director of the Westfield Building and Loan Association forty-five years.

He leaves his wife, Mrs. Anna Belle M. Kinch, and a son, Frederick A. Kinch 3d, of Great Neck, Long Island, and two grandchildren.

The Union County Medical Society adopted the following resolutions:

Whereas Almighty God in His All-wise Providence has elected to remove from our midst our beloved friend and colleague, Dr. Frederick A. Kinch;

Therefore be it resolved that the Union County, New Jersey, Medical Society has, through his death, sustained an irreparable loss; that his wise counsel and genial greetings will be missed; that we extend to his bereaved family our heartfelt sympathy and best wishes that strength will be given them to bear the sad burden imposed upon them; and that these resolutions be spread upon the minutes of our Society, and a copy sent to the bereaved family.

J. B. HARRISON,
GEORGE S. LAIRD,
CHARLES H. SCHLICHTER,
Committee.

DR. JAMES L. COBHAM

Dr. James Lyons Cobham, of 78 Brinkerhoff Street, Jersey City, died at his home on Monday, October 9, 1939, from acute coronary occlusion.

Dr. Cobham was born in Chicago, Illinois, in 1893. He was graduated from Erasmus High School, and Brooklyn College. He received his medical degree from the University of Pennsylvania in 1917, and was licensed to practice in New Jersey in 1919.

He was Chief Surgeon and President of the Medical Staff of Christ Hospital. Until recently he was Instructor of Surgery at Mount Sinai and Metropolitan Hospitals, New York City; and was also Consulting Surgeon at the State Hospital at Grey-stone.

Dr. Cobham enlisted during the World War, and as Captain in the Medical Corps was stationed at field hospitals, on ships transporting troops, and with British soldiers.

Dr. Cobham was a Fellow of the American College of Surgeons, a member of the American Medical Association, The Medical Society of New Jersey, and the Hudson County Medical Society, and the Caducean Society.

He is survived by his wife, Mrs. Lydia Billings Cobham; a son, James Montgomery Cobham, thirteen; and a sister, Miss Edna Cobham, of Morris-ton.

DR. GEORGE M. CULVER

Dr. George M. Culver, of 25 Glenwood avenue, Jersey City, died at his home on October 19, 1939, following a paralytic stroke.

Dr. Culver was born in Jersey City in 1866. His preliminary education was obtained at Public School No. 6, Hasbrouck Institute, Jersey City. He was graduated from the Bellevue Medical College in 1894.

Dr. Culver served as a member of the Jersey City Board of Education for a number of years. He was a member of, and at one time President of

the Staff, of St. Francis Hospital; and was the first genito-urinary surgeon in the Jersey City General Hospital, now the Medical Center.

Dr. Culver was a former President of the Hudson County Medical Society, serving in 1911-1912. He was a member of the American Medical Association, The Medical Society of New Jersey, Hudson County Medical Society, and the Carteret Club.

Surviving are his widow, Mrs. Carolyn Gardner Comstock; a brother, Dr. S. Herbert Culver and several nieces and nephews.

DR. HERMAN TROSSBACH

Dr. Herman Trossbach, of Bogota, died on October first at the Hackensack Hospital, aged fifty-eight years. Born in Carlstadt, New Jersey, he was a resident of Bogota, New Jersey, for the past sixteen years, and was prominent in the practice of general medicine.

Dr. Trossbach was President of the Bergen County Medical Society in 1926, and was formerly Professor of Pathology in the New York Hospital for Women. He was Director of Medicine at the Hackensack Hospital, and a Fellow of the American College of Physicians.

DR. EDWARD B. ROGERS

Edward Bancroft Rogers was born in Mt. Holly, New Jersey, February 20, 1877, and died May 12, 1939. He graduated from the Philadelphia College of Pharmacy in 1899 and from the College of Physicians and Surgeons, Baltimore, in 1903, and in October of that year began to practice medicine in Collingswood, New Jersey.

There is scarcely an organization or accomplishment in Collingswood, during the last thirty years, that did not feel the influence, often the guiding hand, of Dr. Rogers. Indeed of him it is said that with his death "an institution" departed from Col-

lingswood, so potent was his work, so widespread his activity.

During the World War he served in the Medical Corps of the Army. Later he was appointed County Physician and served ten years in that office with great credit.

In the Camden County Medical Society, as with other organizations with which he was associated, he was ever alert, guiding, and often leading in matters affecting the welfare of the medical profession. His standing among his professional colleagues was high, and the community held him in high esteem.

DR. LOUIS J. FERENCZI

Dr. Louis J. Ferenczi, of 33 Edward Court, Bayonne, New Jersey, died at the Bayonne Hospital on July 18, 1939, from carotid aneurysm.

Dr. Ferenczi was born in Bayonne in 1890. His preliminary education was obtained in the local schools, and the Bayonne High School. He received his degree of Doctor of Medicine at Dartmouth Medical College, graduating in 1913. In 1916 he started to practice medicine in Bayonne. He specialized in industrial surgery and was associated with the Standard Oil Company for more than twenty years.

Dr. Ferenczi was a member of the Bayonne Medical Society, the Staff of the Bayonne Hospital, American Medical Association, Medical Society of New Jersey and the Hudson County Medical Society.

Surviving are his wife, Mrs. Anna Lubbering Ferenczi; two sons, Russell H. and Louis M.; five brothers, Daniel, Stephen and Joseph, of Bayonne; Frank, of Binghamton, and August, of Staten Island; and two sisters, Mrs. Wilma Gurka, of Bayonne, and Mrs. Emma Gurka, of Shelter Island.

DECEASED PHYSICIANS—NEW JERSEY

Data Supplied by State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
James L. Cobham	46	Oct. 9	Jersey City	Same	Coronary artery disease.
George M. Culver	73	Oct. 19	Jersey City	Same	Cerebral embolism.
Frank W. Curtis	73	Feb. 9	Portsmouth, Va.	Hackettstown	Cerebral hemorrhage.
Eugene Z. Hillegas	85	Oct. 8	Mantua	Same	Coronary thrombosis.
Frederick A. Kinch	79	Oct. 25	Westfield	Same	Arterio sclerosis.
Ephraim R. Mulford	59	Mar. 10	Charlottesville, Va.	Burlington	Coronary occlusion.
Mordecai M. Pinsky	38	Oct. 6	Camden	Camden	Coronary thrombosis.
Herman Trossbach	58	Oct. 1	Hackensack Hosp.	Bogota	Chronic nephritis.
Howard J. Westney	54	Oct. 18	Atlantic City	Same	Arterio sclerosis.

NUMBER OF CHILDREN REPORTED AS RECEIVING FREE STATE BIOLOGICALS
FROM JULY 1, 1939, TO OCTOBER 31, 1939

DIPHTHERIA TOXOID

SMALLPOX VACCINE

County	Total to Sept. 30	Month of October	Total to Oct. 31	Average per Month	County	Total to Sept. 30	Month of October	Total to Oct. 31	Average per Month
Atlantic	67	11	78	19.5	Atlantic	81	98	179	44.7
Bergen	70	297	867	216.7	Bergen	1100	225	1325	331.2
Burlington	21	11	32	8.	Burlington	163	37	200	50.
Camden	696	16	712	178.	Camden	644	62	706	176.5
Cape May	29	3	32	8.	Cape May	42	9	51	12.7
Cumberland	12	10	22	5.5	Cumberland	79	9	88	22.
Essex	2674	617	3291	822.7	Essex	1737	530	2267	566.7
Gloucester	46	3	49	12.2	Gloucester	133	4	137	34.2
Hudson	2259	71	2330	582.5	Hudson	2588	173	2761	690.2
Hunterdon	0	0	0	0	Hunterdon	15	25	40	10.
Mercer	528	57	585	146.2	Mercer	553	219	772	193.
Middlesex	71	111	182	45.5	Middlesex	235	228	463	115.7
Monmouth	786	7	793	198.2	Monmouth	164	36	200	50.
Morris	206	28	234	58.5	Morris	386	83	469	117.2
Ocean	0	0	0	0	Ocean	18	0	18	4.5
Passaic	1001	169	1170	292.5	Passaic	939	115	1054	263.5
Salem	43	21	64	16.	Salem	117	69	186	46.5
Somerset	43	7	50	12.5	Somerset	348	25	373	93.2
Sussex	0	1	1	.2	Sussex	0	0	0	0
Union	484	193	677	194.2	Union	679	418	1097	274.2
Warren	7	8	15	3.7	Warren	98	12	110	27.5
Totals	9543	1641	11184	2796.	Totals	10119	2377	12496	3124.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

DECEMBER, 1939

5 Camden	14 Burlington
5 Hudson	14 Essex
8 Atlantic	14 Passaic
8 Salem	14 Somerset
12 Bergen	20 Middlesex
12 Cumberland	21 Gloucester
13 Mercer	21 Morris
13 Ocean	27 Monmouth

JANUARY, 1940

2 Camden	11 Somerset
2 Hudson	12 Atlantic
9 Bergen	12 Salem
10 Mercer	16 Warren
10 Ocean	17 Middlesex
10 Union	18 Gloucester
11 Burlington	18 Morris
11 Essex	23 Hunterdon
11 Passaic	24 Monmouth

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held at the Ambassador Hotel in Atlantic City November 10, 1939, Dr. Edward F. Uzzell, President, presiding.

SCIENTIFIC

Dr. Lester J. Unger, Professor of Medicine, Columbia University, spoke on "The Value of Transfused Whole Blood, Citrated Blood, and Preserved Blood". Dr. Unger stated the cardinal principle to be that "When transfusion is indicated, the nearer you come to giving blood as it exists in the body of the donor, the more certain you are to meet the requirements of the patient." Whole, unmodified, fresh blood is therefore the blood of choice no matter what the indication.

But because of convenience and ease of administration, the administration of *citrated* blood has risen in popularity. Reactions are more apt to occur when blood is modified, and in citrated blood there is a change in the blood platelets, the fragility is increased and there is a general tendency to hemolysis. Sodium citrate is also known to decrease the complement, thereby lessening the value of citrated blood in combating acute infection. Should frequent citrated blood transfusion be given to a given patient, that individual may develop a delayed coagulation time as a result of the sodium citrate. Renal damage must also be guarded against.

Considerable interest has been stirred up by the Russian method of using *cadaver blood* as an easily available source of stored blood. However, besides the esthetic objections several technical difficulties arise. Only blood from cases of sudden death, collected within eight hours in winter, and six hours in summer, can be used. The average cadaver will yield 2500 to 3000 c.c. It is claimed that is suitable for use within twenty-one days.

The popularity of *blood banks* was noted by Dr. Unger. The object here, of course, is to obtain blood when it is not needed, to be kept available when needed. This blood must of course be preserved the same as cadaver blood, therefore it has all the objections of citrated blood. The claims as to the length of time it keeps without hemolysis have gradually decreased until now it is being agreed

that it should be used within ten days. Because of storage problems and possible waste, it is still not an advisable method for small hospitals.

Dr. Unger aptly pointed out that the facility of the citrate method has given rise to an unwarranted number of transfusions, with a resultant high incidence of reactions and therapeutic failure when the necessity and specificity of the transfusion as a therapeutic measure have not been properly evaluated.

Drs. V. E. Johnson and R. A. Kilduffe discussed the paper.

VISITING NURSES

The Public Health Committee approved the standing orders under which visiting nurses perform their duties.

TELEPHONE LISTINGS

A new committee consisting of Dr. Kilduffe, Dr. Irwin and Dr. Crane were appointed to interview an official of the Bell Telephone Company in an effort to improve the listing of Atlantic County physicians, particularly to distinguish those practicing regular medicine from the varied licensed practices.

AUTO INSIGNIA

Official A. M. A. auto insignia are obtainable from the Treasurer on the payment of \$2.25.

BERGEN COUNTY

A. T. V. Brennan, Jr., M.D., Recorder

The regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital on October 10th, 1939. The meeting was preceded by an informal discussion of office procedure.

MEMBERSHIPS

The following were elected as junior members:

William Deuell, Hackensack, N. J.
Albert Gladstone, Paramus, N. J.
Harold J. Megibow, Ramsey, N. J.
A. N. Sarajian, West Englewood, N. J.
Vincent Belegri, Rochelle Park, N. J.

From Junior to regular membership—

Russel M. Maddren, M.D., Hackensack, N. J.
Herbert R. Mores, M.D., Ridgefield Park, N. J.

To Regular Membership—

Albert J. Beres, M.D., Woodridge, N. J.

To Regular Membership by Transfer—

Charles D. Roberts, M.D., Englewood, N. J.,
from Suffolk County (Mass.) Medical Society.

The annual banquet of the Bergen County Medical Society will take place on November 30th, under the direction of Dr. F. J. Vita, Chairman of the Entertainment Committee.

SCIENTIFIC

The Scientific Committee presented a program on the "Newer Aspects of Pre- and Post-Operative Care".

The speakers were: Harry A. D. O'Connor, M.D.; John H. Mulholland, M.D.; J. A. Lowler, M.D.; and Samuel Standard, M.D. They are all members of the Third Surgical Division of the Bellevue Hospital.

BURLINGTON COUNTY

Paul R. Sparks, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on October 12, 1939. President Munro called the meeting to order at 9:15 p. m., welcoming Drs. Diverty, Crane, Platt, Neufeld, and Ziccardi, and Mrs. Ruby M. Freer as visitors.

MEMBERSHIP

Dr. John R. Siddal was elected to membership, and one application was received.

BABY KEEP-WELL STATION

The application of Dr. William Wells was accepted as physician to the Delanco Baby Keep-Well Station, replacing Dr. Freeman Metzger, who resigned.

HEALTH PROGRAM

Mrs. Ruby M. Freer, Executive Secretary of the Burlington County Tuberculosis League, presented a summary of the aims of the League and described a proposed conference with interested physicians on the subject of "Guidance of Health" program for school children, to be led by an authority in the field. On motion of Dr. LeFavor the matter was referred to the Program Committee.

SCIENTIFIC

Dr. Shipps presented the speaker of the evening, Dr. Clifford Lull, Assistant Professor of Obstetrics at Jefferson Medical College, who gave a thorough résumé of the subject "Toxemias of Pregnancy". Their classification, diagnosis, and treatment were described. An open discussion on various phases of obstetrics followed.

November Meeting

The one hundred and tenth annual meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on November 9, 1939. President Munro presided, and welcomed Drs. Diverty, Wood, Ziccardi, and Newmeyer, as visiting guests.

ADMINISTRATIVE PROBLEMS

Secretary Rodman presented a bulletin from the headquarters of the State Society calling attention to three practical problems:

1. The medical care of indigents.
2. Workmen's Compensation.
3. Costs of medical care.

TREASURER'S REPORT

The Treasurer, in his report, presented a communication from the office of the State Society in explanation of the increase in State dues from \$14 to \$17 per member. Upon motion regularly made, seconded, and carried, the dues for the coming year were fixed at \$25, which includes the State assessment.

FALL CLINICAL CONFERENCE

Dr. Shipps reported that he had attended the Fall Clinical Conference in Jersey City on November 9 and 10, and had been much impressed with the splendid program.

SCIENTIFIC

Dr. J. C. Lovett, of the Municipal Hospital, Camden, gave a practical "Review of the Recent Epidemic of Poliomyelitis".

Dr. E. V. Davis outlined "The Orthopedic Management of Cases of Poliomyelitis".

ELECTION OF OFFICERS

The Nominating Committee—Drs. P. M. Scott, J. M. Kuder and Nathan Thorne—reported the following personnel of officers for the following year:

President-Elect, Dean H. LeFavor

Vice-President, Parry M. Scott

Secretary, E. Warren Rodman

Treasurer, E. Vernon Davis

Reporter, T. Bruce Dickson

Censor, Charles A. Munro

Delegate to State Society (3 years), Paul R. Sparks; alternate, Carlton P. Hogan

Member of Nominating Committee of State Society, S. Emlen Stokes; alternate, Edgar J. Haines

These nominees were unanimously elected to office.

Two members were elected to Committee on Program and Arrangements to serve until 1942—Richard D. Anderson, and Howard C. Curtis.

Visiting delegates were also elected to the county societies of Camden, Atlantic, Gloucester, Salem, Ocean, and Cape May.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the City Dispensary Building on October 3, 1939, at 9 p. m., with President I. E. Diebert presiding. The attendance of members was ninety-four, and Drs. Shipps and Curtis from Burlington were also present.

SCIENTIFIC

A very interesting scientific program was given on poliomyelitis. Dr. A. L. Stone presented the epideminology; Dr. J. C. Lovett reviewed the pres-

ent poliomyelitis epidemic; and Dr. B. Franklin Buzby discussed the orthopedic management.

The discussion was opened by Dr. Vincent Del Duca, and continued by Drs. Denbo and Carlander.

MEMBERSHIP

The Board of Censors and Membership Committee approved the following applications for active membership:

Paul Mecray, Jr., 405 Cooper Street, Camden
S. Seto, Black Horse Pike, Blackwood
L. E. Griscom, 604 Broadway, Camden

DELEGATES

Dr. H. Wesley Jack was elected to the Executive Committee; and Dr. A. M. McCarthy was chosen delegate to the State Society, and Dr. E. C. Shull, alternate.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The *Essex County Medical Society* held its monthly meeting at the Academy of Medicine Thursday, November 9th, 1939. Dr. Royal Schaaf, the President, called the meeting to order promptly at 9 p.m.

ADDRESS OF DR. FISHBEIN

Dr. Schaaf now introduced Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, as the "Champion of the American System of Medicine". He spoke for a full hour and one-half on "American Medicine and the National Government", and held the close attention of the audience, which filled every available space in the auditorium.

He sketched the fight of organized medicine against a relentless group seeking to incorporate their ideas for medical care into legislation. He said that the idea of a central agency to coordinate health activities was suggested early in the history of the government, and all important health legislation in the country has been passed with the aid of the medical profession.

He criticized the national health survey on finding that one-third of the nation is poorly housed, clothed, and fed and receiving no medical and dental care. This calls for a reasonable discount. He said that 48 per cent of the country is still called rural, and that less than a \$1500 annual income of a large number of the people is not so appalling as it may seem. He made it plain that the American Medical Association is fighting false types of medical legislation, low-grade medical practice, and compulsory sickness insurance.

The doctor denied that European totalitarian countries have solved the problem of medical care. He said, "American democracy must not enter into any of those experiments which led to those governments if we are to retain the democracy we now have."

POST-GRADUATE COURSES

Since the last report in the November Journal (page 686) things are shaping up in the post-graduate work. It is now assured that the vision of

affiliation with the New York University College of Medicine has been realized. In the very near future courses will be announced. This will not be limited to members of our society, but any accredited physician in the State may enroll. The committee has worked hard on the arrangements and deserves much credit.

EXHIBIT FOR THE LAITY

Dr. Benjamin Saslow, Chairman of Sub-Committee of Public Exhibits, reports that the Crystal Ballroom of the Mosque Theatre in Newark has been engaged for the coming Exhibit for the Laity next February. The object of the exhibit is to bring to the local public attention a vivid, graphic description of milestones in medical history, and the many recent advances in medical science. Among the speakers listed are such prominent men as Dr. Harrison Martland, Dr. Morris Fishbein, and Mr. J. Edgar Hoover or his personal representative from the Federal Bureau of Investigation. A large group of exhibits will be open to the public during the entire week. Motion pictures also will play an important part.

NEW MEMBERS

The following physicians were elected to membership:

To active membership—

Arthur D. Devlin, Newark
Herbert Greenfield, Newark
Herman I. Roseman, Bloomfield
Harold Schwartz, Newark
K. C. Willis, Upper Montclair
Morris Harris, Bloomfield (by transfer)

To associate membership—

Francis Christoph, Maplewood
Victor Di Leo, Orange
William B. McQuinn, East Orange

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held at 9 p.m. on Thursday, November 16, 1939, under the auspices of the Section on Medicine and Pediatrics, with President Charles M. Robbins presiding.

Dr. Manfred Kraemer, Chairman of the Section, introduced Dr. Nathan Zvaifler, who gave a lantern-slide paper on "Acute Laryngo-Tracheo Bronchitis with Membrane Formation".

Dr. Bela Schick spoke on "Newer Treatment Methods for the Respiratory Diseases of Childhood".

The papers were discussed by Drs. Orton, Hyman, Applebaum, E. L. Smith, Rosenberg, Gregory, Le Roy Wood, and Dubois.

A meeting sponsored by the Committee on Public Health and Medical Education and the Health Committee of the Newark Contemporary was held on Tuesday, November 21, 1939. Dr. Max Danzis, Chairman of the Committee on Public Health and Medical Education, presided, and introduced Dr. Currier

McEwen, Dean of the New York University College of Medicine. Dr. McEwen's paper, "Trends in Medical Education", was a review of medical education in America and was greatly enjoyed by the members and their friends.

PROGRAM FOR JANUARY, 1940

Council Thurs., Jan. 4
Eye, Ear, Nose and Throat Mon., Jan. 8
Medicine and Pediatrics Tues., Jan. 9
Stated Meeting, auspices of the Section on Obstetrics and Gynecology Thurs., Jan. 18
Dr. John F. Hagerty Memorial meeting

Tues., Jan. 23

Eye, Ear, Nose and Throat Section, Monday, January 8, 1940, 8:45 p. m.

Paper: "Eye Muscles", James W. White, M.D., Associate Ophthalmologist, New York Post-Graduate Hospital

Medicine and Pediatrics, Tuesday, January 9, 1940, 8:45 p. m.

Paper: "Modern Aspects of Peptic Ulcer Therapy", Ernest H. Gaither, M.D., Associate in Medicine, Johns Hopkins University.

Stated Meeting, Section on Obstetrics and Gynecology, Thursday, January 18, 1940, 8:45 p. m.

Paper: "Choice of Instrument in Delivery with Forceps" (illustrated by motion pictures), Edward H. Dennen, M.D., Instructor in Gynecology and Obstetrics, Cornell University Medical College.

Dr. John F. Hagerty Memorial Meeting, Tuesday, January 23, 1940, 8:45 p. m.

The Staff of St. Michael's Hospital will present the Academy with a plaque in memory of the late Dr. John F. Hagerty, Medical Director. Frank H. Lahey, M.D., Boston, will be the guest speaker.

A conference of the members of the State Maternal Welfare Committee, the Maternal Welfare Committees of the Counties, and all Field Physicians of New Jersey will be held at the Essex House, 1050 Broad Street, Newark, on Thursday, January 18, 1940. Field Physicians will meet at 3 p. m., and the Maternal Welfare Committees at 4 p. m., with an informal dinner at 7 p. m.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Homestead Coffee Shop in Woodbury on Thursday, November 16, 1939, with President H. W. Wright presiding, and thirty-two members present (70 per cent of the membership).

SCIENTIFIC

Dr. Arthur W. Bingham, East Orange, Chairman of the Advisory Committee on Maternal Welfare of The Medical Society of New Jersey, discussed the death rates of mothers from childbirth, as compared with the rates for the rest of the State (Journal, August, 1939, p. 510), and offered suggestions for reducing the rates in Gloucester County.

Dr. Norris W. Vaux, Professor of Obstetrics, Jefferson Medical College, Philadelphia, gave an address on "The Anemias of Pregnancy".

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular business meeting of the *Hudson County Medical Society* was held on Thursday, November 9th, 1939, at 5:15 p. m. in the Carteret Club, Jersey City, with the Vice-President, Dr. George Ginsberg, presiding.

NEW MEMBERS

The following new members were admitted to the society:

G. C. Brignola, Hoboken
Harry Handler, Jersey City
Roman T. Lakiszak, Jersey City
James A. McCarron, Bayonne
Edward V. Padney, Jersey City
Lester Siegel, Jersey City

Two proposals for membership were received.

HOSPITAL SERVICE PLAN

The Executive Committee made a preliminary report on the proposal that the Hudson County Medical Society should insure its members in the "Hospital Service Plan of New Jersey" in order to provide hospital care for members who were sick, and for their families.

SCIENTIFIC SESSION

The scientific session was held in conjunction with the Fall Clinical Conference of The Medical Society of New Jersey held in Hudson County on November 9th and 10th, 1939.

HUNTERDON COUNTY

Arthur M. Jenkins, M.D., Reporter

The regular quarterly meeting of the *Hunterdon County Medical Society* was held on the evening of October 24th, 1939, in Flemington, with President J. J. Cartisser presiding, and nineteen members present.

FIFTY YEARS OF PRACTICE

Dr. Theodore F. Fulper, of Hampton, was presented a certificate and gold key honoring his fifty years of service as a general practitioner in Hunterdon County. Dr. Fulper began practice on April 3, 1889. In a brief address of acceptance, he disclosed many interesting facts regarding the methods of treatment and diagnosis of that time, as compared to medicine as it is practiced today.

RESIGNATION OF DR. EDWARD CLOSSON

Dr. Edward W. Closson, of Lambertville, presented his resignation from the Society on account of illness. Dr. George N. J. Sommer, of Trenton, an honorary member of the Hunterdon County Medical Society and Fellow of The Medical Society of New Jersey, paid tribute to Dr. Closson for his long years of service particularly as Treasurer of his County Society.

(The Journal of August, 1937, page 537, contains a group photograph of the members taken on July 27, 1937, when Drs. Closson, Apgar, and Harman were given keys and certificates in honor of their attainment of fifty years of practice. Drs. Fulper, Closson, Apgar, Harman, and Sommer all appear in the group.)

PUBLIC RELATIONS

Dr. Edgar P. Cardwell, of Newark, representing the Public Relations Committee, outlined several phases of the work that is being done in acquainting the public with the State medical program. He also presented several plans for the County Society to pursue in furthering the work of the committee. Dr. Wilkes, Executive Officer of the State Medical Society, also emphasized the need of public relations in Hunterdon County.

UNDULANT FEVER

Dr. Frank G. Scammell, of Trenton, gave an interesting talk on undulant fever and the obvious increasing number of cases occurring in the rural districts. Much in the way of limiting this disease could be accomplished through the Public Relations Committee and its contacts with the farmers whose cattle may possibly be infected.

MEMBERSHIP

Dr. A. John Bambara was elected to membership in the County Society, and two physicians were proposed for membership.

ACCOUNT BOOKS OF 125 YEARS AGO

Dr. Frank Overton, Editor of The Journal, called the attention of members to a series of ledgers and day books kept during a period of twenty years from about the year 1800, by Dr. John Bowne, of Hunterdon County. The books are written legibly; and their records are full and clear, and reveal the daily round of practice of an up-to-date doctor 125 years ago. The books are in the library of the Hunterdon County Historical Society in Flemington.

MIDDLESEX COUNTY

Howard Dieker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Middlesex General Hospital, New Brunswick, on Wednesday evening, October 25th, 1939. The President, Dr. N. N. Forney called the meeting to order at 9:20 p. m.

SCIENTIFIC

Dr. William A. Pearson, Dean of the Hahnemann Medical College of Philadelphia, read a paper on the subject of "The Problem of Medical Education Today".

Dr. Arthur Bingham, Chairman of the State Committee on Maternal Welfare, spoke on the results of his committee's work throughout the State. He advised our society to adopt the Community Prenatal Plan in the areas not served by clinics. Dr. Nichol, of Dover, accompanied him and discussed the prenatal work done in his county, Morris.

MEMBERS

The following associate members were elected to full membership:

J. J. O'Connell, of New Brunswick
Irwin Fine, of Perth Amboy
Malcom Dunham, of Woodbridge
W. A. Balogh, of Dunellen

The following were elected to associate membership:

Sidney Smith, of Highland Park, N. J.
C. E. Lewis, of New Brunswick, N. J.

Dr. Walter Kiefer was given a transfer to Nassau County, New York Medical Society, he having moved to Lynbrook, Long Island.

BUSINESS

Dr. Uhr of the Committee on Post-Graduate Work reported the society decided that, if the committee could get the written consent of at least fifty members to take the course, that the committee could make arrangements with the Extension Division of Rutgers to give the course.

The society endorsed the work of the State Venereal Clinic at Cranbury.

The meeting was adjourned at 11:40 p. m.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

A meeting of the *Executive Committee* of the Monmouth County Medical Society, together with the chairmen of the various committees, was held at the home of the President, Dr. R. A. MacKenzie in Interlaken, N. J., on Monday evening, October 9th, 1939.

APPROPRIATIONS FOR SPEAKERS

Dr. Carlos Pons brought up the subject of speakers for the meetings. He suggested that an appropriation of \$15.00 be allowed for one speaker per evening. The matter was discussed, and it was moved and seconded that the Program Committee be authorized to allow \$15.00 for each out-of-town speaker, but not more than five be permitted during a year.

HOSPITAL STAFF MEETINGS

It was moved and seconded that the dates of the Staff meetings of both the Monmouth Memorial Hospital and the Fitkin Memorial Hospital be mentioned in the Monthly Bulletin.

Reports were received from the Chairmen of the Public Relations Committee, Medical Practice Committee, Public Health Committee, and its subcommittees. Dr. Pons gave a résumé of the programs for the coming year, which gave promise of being very interesting. The Public Health Work was discussed by the chairman of each committee. In general, the local activities will coordinate with the projects and aims similar to those of the State committees, and they will work in conjunction with them.

The regular meeting of the *Monmouth County Medical Society* was held on October 25th, 1939, at the Molly Pitcher Hotel in Red Bank. The meeting was addressed by Dr. Harold Hyman, Associate Professor of Pharmacology at Columbia University. Dr. Hyman gave a very interesting talk on the newer drugs and the method of their administration.

PERSONAL NOTES

Dr. D. M. P. Magee has given up his practice in Asbury Park. He is now Urologist to the State Hospital in Trenton.

Drs. M. Q. Hancock, S. O. Wilkins, and S. T. Miller are taking full-time courses at the University of Pennsylvania. Part-time courses are being taken at Mt. Sinai, New York, by Drs. C. C. Perrine, L. F. Albright, F. J. Altschul, H. H. Freedman, and A. Rosenthal.

MORRIS COUNTY

F. Clyde Bowers, M.D., Reporter

On the evening of October 19, 1939, the *Morris County Medical Society* held its first clinical meeting of the Fall season at Greystone Park Hospital. An estimated three-fourths of the entire membership, probably the largest group ever to attend a county clinical meeting, assembled at the hospital, and after a brief business meeting, listened attentively to Dr. Norman Plummer, who spoke on "The Treatment of Pneumonia". Dr. Plummer, who is well versed in the subject of pneumonia, confined his remarks mostly to the newer concepts of therapy in this disease, namely sulfapyradine and serum. The subject was exceptionally well presented and was enthusiastically received, as evidenced by the long discussion which followed.

The meeting then adjourned and those present enjoyed refreshments in the hospital cafeteria.

The next regular meeting will be December 21, 1939.

OCEAN COUNTY

L. R. Carmona, M.D., Reporter

The regular monthly meeting of the *Ocean County Medical Society* was held at the Lakewood Country Club, Lakewood, N. J., on the evening of November 8th, 1939, with the President, Dr. J. Edwin Obert, presiding and twenty-two members and five visitors present.

SCIENTIFIC

The guest speaker was Dr. Walter F. Kinney, Professor of Urology, Jefferson Hospital, Philadelphia, Pa., whose subject was "Urinary Retention and Methods for Its Relief". The methods Dr. Kinney presented were informal and practical, and can be used in our every-day practice for this particular type of patients.

Dr. McIlvaine opened for discussion and questions, and comments were offered by Drs. Halbach, Taylor, and Menge.

Dr. Dodd introduced Dr. E. J. Marsh, who represented President Hawkes. His message emphasized the necessity of solving two important problems:

1. The care of the indigent.
2. Proper legislation for group insurance of the low-wage income group.

Dr. Marsh stressed the hope that all medical societies would make an effort to enroll for membership all qualified, ethical physicians.

Dr. Scott emphasized the importance of the offi-

cial message presented by Dr. Marsh, the Second Vice-President.

THE WOMAN'S AUXILIARY

Dr. Buermann reported the four-point plan of the Woman's Auxiliary:

1. The advisability that the physicians of the Ocean County Medical Society join the "Society for the Relief of Widows and Orphans of the Medical Men of New Jersey".

2. Memorial books to be placed in various libraries of the county in memory of deceased physicians.

3. An Essay Contest on Health during 1940, open to the high school students of the county. Twenty-five dollars in prizes will be distributed by the society.

4. A list of Ocean County physicians who will address lay audiences on public health topics, on assignment by the Woman's Auxiliary, coöperating with the County Society.

These plans were approved by the Ocean County Medical Society.

The next meeting will be held on December 13, in the Lakewood Country Club.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at Valley View Sanatorium, in Breakneck, on Thursday, November 9, 1939, at 9 p. m. President Wayne Hall, M.D., presided.

NEW MEMBERS

The following members were elected:

To active membership:

Joseph M. Keating, Passaic
Sidney Gelman, Paterson
Andrew F. McBride, Paterson
Thomas F. Reilly, Clifton

To associate membership:

Quinby D. Gurnee, Hawthorne
Michael J. Romano, Paterson
David Zuckerman, Paterson

One application was received for active membership, and two for associate membership.

PRESIDENT'S CABINET

Dr. Watson B. Morris, President-Elect of The Medical Society of New Jersey, spoke on "Current Activities of the State Society", particularly the following:

1. Voluntary health insurance, and he said that when the legislation had been passed this would be put into effect.

2. Proposed changes in the compensation law.

3. The report of the Hospital Relations Committee.

4. National Health program.

He pointed out what the State Society was doing in these lines, and complimented the Passaic County Bulletin as a source of information to the officers of the State.

SCIENTIFIC

Dr. George G. Ornstein, Director of Tuberculosis of the Sea View and the Metropolitan Hospitals of New York City, described "The Modern Concept in the Control of Tuberculosis". He emphasized the importance that the collapse treatment of the lungs be done early if it is needed at all. The results of the early performance are far more favorable than those of a late operation when extensive destruction has taken place.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The regular meeting of the *Salem County Medical Society* was held November 17, 1939, at the Grey Stone Inn, Woodstown, N. J. President C. S. Davison presided at the meeting, which was well attended.

MEMBERSHIP

Dr. W. D. Norwood, of the DuPont Dye Works Hospital, was admitted to membership in the society.

SCIENTIFIC

A paper on "Lesions of the Breast" was given by Dr. J. G. Spackman, of the Homeopathic Hospital, Wilmington, Delaware. It was discussed by Drs. D. W. Green, and L. C. Hummel, of Salem. The paper was on a subject encountered continually by all physicians, and was most instructive and enjoyable.

Following the meeting, dinner was served at the Inn.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

On Wednesday evening, November 8, 1939, the regular meeting of the *Union County Medical Society* was held at the Bonnie Burn Sanatorium, Scotch Plains, N. J. President Rowland P. Blythe presided.

DUES

It was moved and seconded that the annual dues remain at \$25.00 a year. Following a brief discussion, this was carried by unanimous vote.

NEW MEMBERS

The following physicians were elected to membership:

Hubert Humphrey, 430 Donner Street, Westfield
John McGeary, 712 North Broad Street, Elizabeth
Charles Yellin, 525 East Second Avenue, Roselle Park
Ralph Vitolo, 934 Orchard Terrace, Linden

SCIENTIFIC

Immediately after the brief session of business, Dr. J. E. Runnells, Medical Director of the Sanatorium, gave a short summary of the work being

done at the Sanatorium, and introduced the speaker of the evening, Herbert R. Edwards, M.D., Director of the Bureau of Tuberculosis, Department of Welfare, New York City.

Dr. Edwards presented an unusually concise picture of some newer concepts in the fight against tuberculosis. He indicated the particular methods by which the Public Health Departments of every community would find their work facilitated. This included the importance of, first, case findings; second, case supervisions; and third, rehabilitation. He emphasized particularly the importance of the family physician's examination, and the value of his coöperation with the existing tuberculosis organizations and institutions. He discussed the necessity for providing the largest number of adequate diagnosis and treatment methods at the lowest possible cost for the community, and explained how this had been accomplished by the newest advancements in x-ray work. Dr. Edwards showed how this program has been successfully carried on in New York City; and at the close of his talk he emphasized the importance of the individual practicing physician in relationship to the control of tuberculosis.

Refreshments were served by the hospital management.

SUMMIT MEDICAL SOCIETY

E. H. MacPherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held at the Beechwood Hotel on Tuesday evening, October 31st.

Dr. J. F. Johnston, of Chatham, the Vice-President, presided, with thirty members and eight guests present.

Dr. John Caffey, of Babies' Hospital, New York City, gave an illustrated lecture on "The Value and Limitations of X-Ray in Diagnosis of Primary Tuberculosis".

Following the discussion, refreshments were served.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The annual meeting of the *Warren County Medical Society* was held in Belvidere, at the Hotel Belvidere, Tuesday, October 18, 1939, at eleven o'clock, with the President, Dr. W. R. Bostwick, presiding and twenty members present.

QUARTERLY MEETINGS

It was moved and seconded that Article IV of the by-laws of the society be amended to read: The Society shall meet annually at Belvidere, N. J., the third Tuesday in April. Quarterly meetings shall be held on the third Tuesday of July, October and January.

This amendment will be considered at the next meeting.

Amendment was proposed that this society shall have an Executive Committee consisting of Past

President, President and Secretary of the society with the addition of two elective members each serving for one year as an amendment to Article V of the by-laws.

This amendment will be considered at the next meeting.

NEW MEMBER

Dr. J. C. Humbert, of Stewartsville, was elected to membership.

ELECTION OF OFFICERS

Drs. Shimer, Bloom and Drake were appointed members of the Nominating Committee, which reported the following nominations:

President, Ralph Buchanan, Phillipsburg
Vice-President, C. A. Maxwell, Hackettstown
Secretary, N. C. Marlatt, Belvidere
Treasurer, G. W. Cummins, Belvidere

Delegate to State Society and member of the Nominating Committee: Dr. F. A. Shimer, Phillipsburg

Censors: H. Baldauf, A. C. Zuck and L. Bloom

Members of Executive Committee: F. Drake and William Varney

All these officers were elected.

SCIENTIFIC

Dr. B. M. Hance, Urologist at Easton Hospital, Easton, Pa., gave a very interesting paper on sterility which was discussed by several members present.

DINNER

The meeting then adjourned to the dining room, where the members were joined by the members of the Ladies' Auxiliary and a turkey dinner was enjoyed.

PUBLIC RELATIONS OF COUNTY MEDICAL SOCIETIES

A COUNTY SOCIETY EDITORIAL

One of the most striking evidences of the great progress in the activities of county societies is their public relations programs. The editors of newspapers, both local and metropolitan, are eager to obtain news regarding the medical societies; and organizations of a civic nature are eager to place local physicians on their programs.

It is entirely ethical that a local doctor shall be publicly announced as a speaker who will appeal to laymen to support a public health program of his county society, for the society is the medical adviser of welfare organizations and local officials of the government. Local doctors can interpret local health needs far more effectively than speakers and writers coming from a distance.

It is no longer true that public relations is a *specialty* to be practiced by a few experts. Every county society—large or small—has "Mute, inglorious Miltons" who need only the assignment by their fellows to express themselves publicly by either speaking or writing. This is demonstrated by the very great increase in the number and scope of the reports printed in this Journal in the department of the Journal devoted to County Societies. It is further demonstrated by the Monthly Bulletins which are now issued by most county societies.

Turn to the *Annual Index* that is printed on pages 751-758 of this issue of the Journal: and note that the index of County Society Activities fills as much space as that of the activities of the State Society.

THE WOMAN'S AUXILIARY

THE NATIONAL WOMAN'S AUXILIARY

Reported by MRS. G. E. McDONNEL, President, the New Jersey Auxiliary

The Board of Directors of the Woman's Auxiliary to the American Medical Association met at the Palmer House, Chicago, Illinois, on Thursday and Friday, November 16 and 17, 1939.

On Thursday we were entertained at luncheon by the Auxiliary of Illinois, and were taken on a tour of inspection of the Museum of Science and Industry. This is designed to house the most complete and scientific exhibit of the medical sciences in the United States.

The business session of the Board was held on Friday, November 17th, at 9:00 a. m., with about forty members present. The usual routine of business was transacted and reports were given by the committee chairmen and State Presidents. I was very much interested in observing that we of New Jersey were doing all that has been required of us.

One of the unusual events of the morning session was the discussion of a permanent secretary for the Woman's Auxiliary, with headquarters at Chicago, Illinois. It seems that the ever-increasing growth and development of the organization demands a full-time qualified secretary.

The compilation of a complete Auxiliary History from its beginning until the present year has begun.

Plans for the National Meeting were made, and the Auxiliary headquarters will be at the Hotel Pennsylvania in New York City during the meeting week of June 10-14, 1940.

All the members of the board had a useful and busy day, and were well repaid for their attendance at this meeting.

The Auxiliary is gradually becoming an important part of the American Medical Association and should be the first interest of every physician's wife in our State. This thought was very beautifully expressed by the President of the Auxiliary from Pennsylvania in the following lines from Dr. Henry van Dyke:

Let me but do my work from day to day,
In field or forest, at the desk or loom,
In roaring market-place or tranquil room;
Let me but find it in my heart to say,
When vagrant wishes beckon me astray,
"This is my work; my blessing, not my doom;
Of all who live, I am the one by whom
This work can best be done in the right way."

Then shall I see it not too great nor small
To suit my spirit and to prove my powers;
Then shall I cheerful greet the laboring hours,
And cheerful turn, when the long shadows fall
At eventide, to play and love and rest,
Because I know for me my work is best.

Atlantic County

Reported by Mrs. Samuel L. Winn

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held Friday evening, November 10th, with Mrs. James H. Mason III presiding. There were thirty members present, and one Auxiliary guest, Mrs. Chester I. Ulmer from Gibbstown.

The Program-Public Health Chairman, Mrs. Daniel Reyner, explained that the program of the Essay Contest, which is conducted in the grammar grades throughout the county, is in readiness for distribution.

Our Public Relations Chairman, Mrs. Ernest Shore, placed two speakers during the month.

The Legislation Committee, with Mrs. Ruffin Stamps as leader, organized a Legislation Study group. The topic and discussion this current month was the Wagner Health Bill.

Our Entertainment Committee, headed by Mrs.

Samuel Gorson, is especially busy this month since a Sweepstakes Dance is being held in the Ambassador Hotel December 2, 1939, to replenish our Welfare Fund. Mrs. Gorson entertained her committee, and delightfully served refreshments after many details were completed in preparation for the dance.

Our Red Cross Committee is doing splendid work. Mrs. Samuel Salasin, who is our Chairman, entertained at a buffet luncheon November 6th. We hope to have a very favorable report to our credit. We are also pledging to make quite a number of garments in response to the Red Cross to be used for the Polish refugees.

Dr. Chester I. Ulmer, of Gibbstown, was our guest speaker on the topic "How to Get Sick".

Our December meeting will consist of a Christmas "White Elephant" Party to be held at the home of Mrs. James Mason in Ventnor, at which time our Christmas donations will be distributed to eight charity organizations.

Bergen County

Reported by Mrs. J. Willis Demarest, Hackensack

The regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held Thursday evening, November 14th, 1939, with Mrs. Raynold N. Berke presiding. There were thirty-five present.

Reports were received from Mrs. L. W. Netz, Treasurer; Mrs. A. Macauley, Recording Secretary; Mrs. F. P. Twinem, Corresponding Secretary; Mrs. Parker Groff, Program Chairman; Mrs. Howard Meyer, Membership Chairman; and Mrs. J. Willis Demarest, Publicity Chairman; and Mrs. Joseph R. Morrow, Chairman of Public Relations.

The speaker was James D. Moore, the Bergen County Inheritance Tax Supervisor, whose subject was "Inheritance Taxes and Wills".

The Auxiliary will sponsor a dessert bridge on November 17th at the Hackensack Golf Club, Oradell, for the benefit of its philanthropic fund. Mrs. Walter J. Farr is chairman.

Essex County

Reported by Mrs. F. S. Forte

The opening meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on Monday, October 23rd, at L. Bamberger & Co., Newark, N. J., with Mrs. William D. Miningham, the President, presiding, and 108 members present. Mrs. Alvah W. Bickner, of Bergen County, Chairman of Legislation of the Woman's Auxiliary to The Medical Society of New Jersey, was also present. The meeting began with a social luncheon.

Mrs. Roy A. Van Ness, Public Relations Chairman, stated that 225 letters were sent to Parent-Teachers Associations from the Speakers' Bureau.

Mrs. William Huber, Co-chairman of Ways and Means Committee, reported that Mrs. Joseph A. Flynn, Chairman, was formulating plans for a Buffet-Supper Dance on December 16th.

Mrs. Anthony Ambrose, Membership Chairman, reported seven new members this month:

Mrs. Francis Weber	Mrs. Charles Cornish
Miss Jane Hawkes	Mrs. Otto Matteke, Jr.
Miss Dorothy Schneider	Mrs. Amedeo Turi

all of Newark, and Mrs. Joseph Di Angelo, of Belleville.

Mrs. Don A. Epler introduced the following luncheon speakers:

Dr. Edward J. Ill extended greetings.

Dr. Earl Snavelly, Chairman of Advisory Board, pledged his support to the Auxiliary.

Dr. Charles M. Robbins, President of the Academy of Medicine, announced plans for a series of educational programs there this winter, including one on Medical Education by Dean McEwen, of Bellevue Hospital, on November 23rd; and a lecture later by Dr. George Crile. Dr. Robbins invited the women to attend.

Dr. Royal A. Schaaf, President of the Essex County Medical Society, asked the coöperation of the Auxiliary in a public relations program to be sponsored by the society February 5th to 10th, 1940. The program will be held in the Mutual Benefit

Building, Broadway, Newark, and will include evening lectures on such subjects as syphilis, cancer, and tuberculosis, by speakers of national reputation, motion pictures and a series of exhibits on cardiac and metabolic disorders, contagious diseases, etc.

Mrs. Parker O. Griffith, President of the Griffith Music Foundation, spoke on "Town Hall Lecture Series", of which the Academy of Medicine is a sponsor.

Mrs. Leo J. Hammill, drama chairman of the Contemporary of Newark, gave a book review, "The Horse and Buggy Doctor."

Hudson County

Reported by Mrs. Sydney Chayes

The *Woman's Auxiliary to the Hudson County Medical Society* met Monday, November 7, 1939, at the Young Women's Christian Association, Fairmount Avenue, Jersey City, N. J. Mrs. Arthur Largent, the President, presided.

Reports of the various committees were given; and two new members were welcomed, Mrs. James Wheeler, of Jersey City, and Mrs. Ralph Doran, of Hoboken, N. J.

Mrs. Joseph Ruvane, Chairman of Program, introduced the guest speaker, George Keenan, Jr., a resident of Bayonne, New Jersey, recently returned from Europe, having spent some time in Italy and Germany. He gave an account of the reaction of these countries to the religious, political and economic situation.

Mrs. Charles B. Russell, a member of the Passaic Medical Auxiliary, spoke briefly on the Widows and Orphans Fund; and Mrs. Richard McDonald, President-Elect of the New Jersey State Medical Society Auxiliary, spoke on public relations.

The members of the Auxiliary will assist in receiving the visiting doctors; and also will help in the motor corps during the Clinical Conference of The Medical Society of New Jersey being held November 9 and 10.

Early reservations were requested for the Beef-steak Dinner which the Auxiliary will hold on November 29, 1939, at the Union Club in Hoboken for the members and their husbands and friends. Cards will be played and tea served at the Essex House, New York City, January 13, 1940, for the benefit of the Auxiliary's Benevolent Fund.

The next meeting of the Auxiliary will be a Christmas Party December 4th.

At the tea hour, Mrs. Edward Waters poured. She was assisted by Mrs. Miles Long, Mrs. Oscar Jacks, Mrs. Ralph Doran, Mrs. Sydney Chayes.

Mercer County

Reported by Mrs. Catherine F. Chianese

The first regular meeting of the *Woman's Auxiliary to the Mercer County Medical Society* was held on Monday, November 13th, at 2:30 p. m., at the Y. W. C. A. Building, with our President, Mrs. James J. McGuire, presiding, and twenty-six members present.

Mrs. Paul Klempner, Treasurer, reported that sufficient funds are in the Benevolent Fund treasury to carry on the Student Nurse project for the entire three years.

Mrs. Charles F. Adams, Chairman of the Nurse Scholarship Committee, reported on the progress of the work.

Mrs. C. Chester Chianese reported on the October State meeting. (Jour., Nov., p. 692.)

Plans were discussed for the State Auxiliary open meeting, to be held at the Y. W. C. A. Building on January 8th, with Mercer County Auxiliary the host.

The meeting was preceded by a delicious luncheon served at one o'clock with Mrs. William C. Ivins in charge.

We were happy to welcome a new member, Mrs. Norman M. Scott.

Ocean County

Reported by Mrs. Emanuel M. Sickel, Chairman

The regular meeting of the *Woman's Auxiliary to the Ocean County Medical Society* was held Friday afternoon, November 3rd, 1939, at the home of Mrs. William E. Dodd, of Beach Haven. Those present besides the hostesses were Mesdames Bunnell, Buermann, Armona, Goldstein, Halbach, Menge, Obert and MacIlvaine. Mrs. A. Goldstein, of Lakewood, presided and gave her report of the State meeting in Camden on October 9th, at which time the Ocean County Auxiliary received much approbation for its activity in view of its limited membership. Another report was given by Mrs. Robert Buermann, Public Relations Chairman, concerning the meeting of her committee with the Advisory Board of the Ocean County Medical Society. Announcement was made of a Health Essay Contest to be sponsored throughout the county by the Woman's Auxiliary. More definite information will be announced as received from the State.

A most interesting talk was given by the guest speaker, Mrs. Sara Hernberg, who told of South America and the medical aspects of our influence there. Miss Jane Penrod, student of music at the Trenton State Normal School, sang several Spanish compositions. Refreshments were served and a social hour enjoyed, after which the meeting was adjourned.

Passaic County

Reported by Mrs. Joseph E. Mott

The *Woman's Auxiliary to the Passaic County Medical Society* opened its Fall season with a regular meeting and tea at the home of the new Presi-

dent, Mrs. Ralph J. Vreeland, of Ridgewood, N. J., on Monday, October 23, 1939. The meeting was well attended, and all the members listened with great interest to Dr. Hans Wassing, Neuro-Psychiatrist of the Barnert Hospital, and Hope Dell, who spoke on "The Problem Child".

Reports of committees were given by Mrs. Andrew F. McBride, Chairman of Widows and Orphans Committee; and Mrs. L. L. Wientraub, Chairman of Public Relations Committee.

An excellent program of piano selections ranging from concert music to the modern swing was given by Mrs. M. F. Bireley. Tea was poured by Mrs. G. E. Tuers and Mrs. William Spickers, Past Presidents of the Auxiliary.

Union County

Reported by Mrs. Rowland P. Blythe, Publicity Chairman

A regular meeting of the *Woman's Auxiliary to the Union County Medical Society* was held Wednesday evening, November 8th, at Bonnie Burn Sanatorium at Scotch Plains, with the President, Mrs. Herschel S. Murphy, presiding.

Reports were received from the several chairmen, and plans for a reciprocity tea were discussed, naming Mrs. H. V. Hubbard, of Plainfield, Chairman.

One of our members, Mrs. N. W. Currie, of Plainfield, reviewed the book "A Doctor Without a Country", by Dr. Thomas Lambie.

At the conclusion of the meeting a social hour was enjoyed, and refreshments were served by the hospital management.

MEMBERSHIP TEA

A membership tea was held on October 26 at the home of Mrs. Rowland P. Blythe, of Cranford. Our State President, Mrs. G. E. McDonnel, of Mount Holly, was guest of honor. Introduced by the County President, Mrs. McDonnel gave an inspiring talk, and urged members to take an active part in the several clubs of their communities, particularly the Parent-Teacher Association; and to serve on committees pertaining to the furtherance of public health.

About thirty-five members and guests were present, and seven new members were taken into the club. Mrs. Blythe was assisted by Mrs. Carl G. Hanson, of Cranford; Mrs. L. C. V. Du Busc, Mrs. D. R. McElhinney, Mrs. George Knauer, of Elizabeth; Mrs. William C. Meincke Jr., of Roselle, and Mrs. W. J. Hallock, of Summit. Mrs. Friend P. Gilpin, of Cranford, and Mrs. H. V. Hubbard, of Plainfield, poured.

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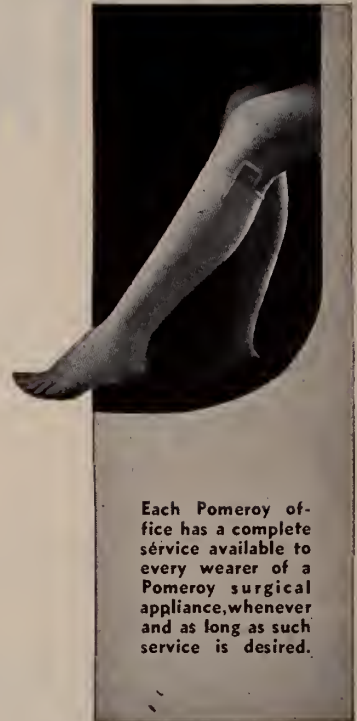
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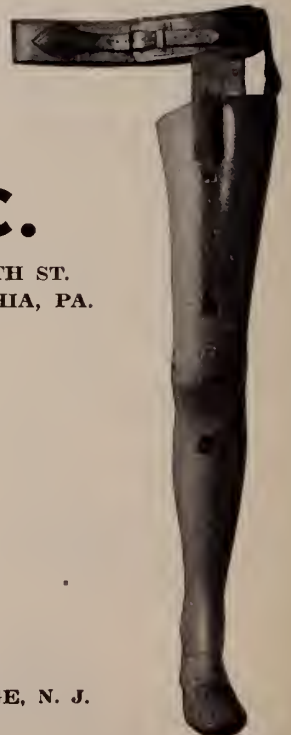
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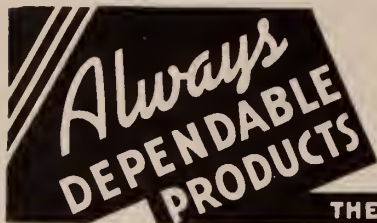
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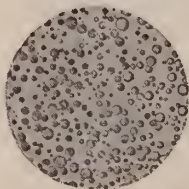


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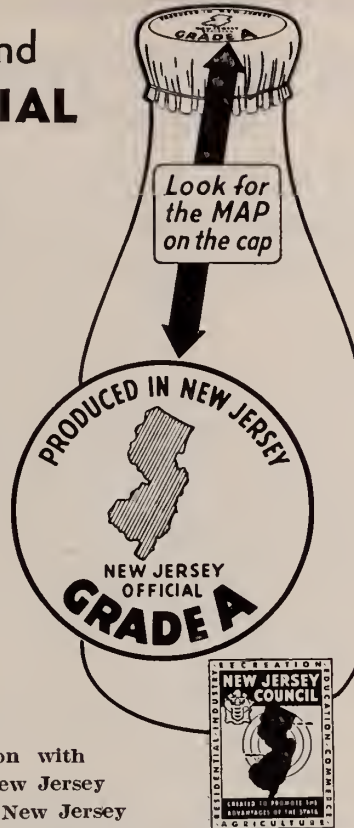
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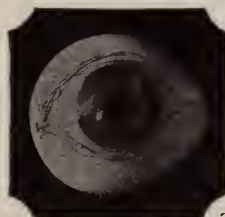
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\$25.00 weekly indemnity, accident and sickness	\$33.00 per year

\$10,000.00 accidental death	For
\$50.00 weekly indemnity, accident and sickness	\$66.00 per year

\$15,000.00 accidental death	For
\$75.00 weekly indemnity, accident and sickness	\$99.00 per year

37 years' experience under same management

\$1,700,000 INVESTED ASSETS
\$9,000,000 PAID FOR CLAIMS

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**Assures a more normal
fecal consistency.**

1. Petrolagar is more palatable. Easier to take by patients with aversion to plain oil—may be thinned by dilution.
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3. Does not coat intestinal mucosa. Petrolagar is an aqueous suspension of mineral oil — oil in water emulsion.
4. No accumulation of oil in folds of mucosa.
5. Will not coat the feces with oily film.
6. Does not interfere with secretion or absorption.
7. Augments intestinal contents by supplying an unabsorbable fluid.
8. More even distribution and dissemination of oil with gastro-intestinal contents.
10. Less likely to leak.
11. Provides comfortable bowel action.
12. Makes possible five types of Petrolagar to select from to meet the special needs of Bowel Management.

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with 0.4 Gm. agar in a menstruum to make 100 cc.*



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While Oleum Percomorphum cannot replace the sun, it is a valuable supplement. Unlike the sun, it offers measurable potency in controlled dosage and does not vary from day to day or hour to hour. It is available at any hour, regardless of smoke, season, geography or clothing. A rich source of vitamins A and D, Oleum Percomorphum can be administered in drops, which makes it an ideal year-round antiricketic. Use the sun, too.

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THE 173rd ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

Held in Haddon Hall, Atlantic City, June 6-8, 1939

THE OFFICIAL TRANSACTIONS IN THREE PARTS

PART 1. MINUTES OF THE HOUSE OF DELEGATES---Pages 3-33

PART 2. REPORTS OF SCIENTIFIC FEATURES---Pages 34-38

PART 3. MINUTES OF THE WOMAN'S AUXILIARY---Pages 39-46

Issued as a Supplement to the Journal of The Medical Society of New Jersey, August 1939

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PART ONE

THE MINUTES OF THE HOUSE OF DELEGATES

First Session, Tuesday Afternoon, June 6, 1939

The first session of the House of Delegates of the One Hundred and Seventy-third Annual Meeting of The Medical Society of New Jersey convened in Haddon Hall, Atlantic City, New Jersey, at 2:30 o'clock, June 6, 1939, Dr. William J. Carrington, of Atlantic City, President of the Society, presiding, and Dr. Alfred Stahl, of Newark, Secretary.

1. OPENING EVENTS

PRESIDENT CARRINGTON: I now declare the One Hundred and Seventy-third Annual Meeting of The Medical Society of New Jersey in session.

Prayer was offered by Rev. Warren W. Way of St. James' Church, Atlantic City, closing with the Lord's prayer in which the delegates joined.

Hon. Charles D. White, Mayor of Atlantic City, welcomed the Delegates, the members, and the friends of The Medical Society of New Jersey, and reminded the physicians that they were peculiarly well qualified to treat the civic, as well as the physical, ills of the people.

Dr. Edward F. Uzzell, President of the Atlantic County Medical Society, expressed the greeting of the County Medical Society.

Dr. Henry W. Leeds, President of the Chal-fonte-Haddon Hall Company, welcomed the convention to the hotel.

2. APPROVAL OF MINUTES

PRESIDENT CARRINGTON: The proceedings of the last meetings of the House of Delegates have been printed and distributed. The Chair, therefore, will entertain a motion that the reading of the minutes be omitted.

Upon motion regularly made and seconded, it was voted to dispense with the reading of the minutes.

3. HONORARY MEMBERS

PRESIDENT CARRINGTON: At this time I will call on the Committee on Honorary Memberships, Dr. Lancelot Ely, Chairman.

DR. ELY: After due consideration and deliberation the Committee on Honorary Members recommends for honorary members to The Medical Society for 1939:

Dr. Rock Sleyster, Wauwatosa, Wisconsin, President, the American Medical Association.

Dr. Nathan B. Van Etten, New York City, President-Elect, the American Medical Association.

Dr. Haven Emerson, New York City, Professor of Public Health Practice, Columbia University Medical School.

I move that these distinguished physicians be accepted as honorary members.

The motion was seconded and was adopted unanimously.

4. PRESIDENT'S SUPPLEMENTARY REPORT

(Original report, Jour., May, page 257)

PRESIDENT CARRINGTON: The Medical Society of New Jersey has the right to review the stewardship of the retiring President. At this time it is customary for the House of Delegates to receive his report, but the old order changeth. The report was mailed to each of you three weeks ago, and extra copies were placed on your chairs this afternoon. Some of you read it then; some of you are sitting on it now. Although custom decrees that it be presented here, let us finish the year as we began it, free from tyranny of custom. We have had a stream-line year; let us have a stream-line annual meeting.

Let me give you a text, a definition, and a benediction. The text from Chapter X of the Epistle to the Hebrews reads, "Let us hold fast the profession of our faith without wavering; and let us consider one another to provoke unto love and to good works, not forsaking the assembling of ourselves together."

Next, let us define the term "stream-line". A stream-line meeting *starts on time*. Each session of the House of Delegates will start on scheduled time. If you do not want to be left behind, be here on the split-second time.

A stream-line meeting *overcomes wind resistance*. There will be no long-winded speeches to impede progress.

A stream-line meeting attains high speed by *eliminating friction*. We have much ground to cover. Inasmuch as the year has been free from friction, let us not slow up this Annual Meeting with cantankerous clashes over matters that are irrelevant, immaterial, and inconsequential.

A stream-line meeting *stays on the track*.

With your help we shall proceed in orderly fashion without detour or circumlocution.

A stream-line meeting *arrives on time*. There are no stop-overs for tinkering with trifles or picking picayunes.

Finally, a stream-line meeting *arrives at its destination*. The destination of the 173rd Annual Meeting of The Medical Society of New Jersey is the *formulation of policies*. The doctors of New Jersey are engrossed in scientific problems, and are bewildered by the economic problems which threaten the very existence of medical practice. No House of Delegates of this Society has ever before faced so many really vital problems.

Gentlemen, a solemn duty is ours. The light is green. Let's go.

5. REFERENCE COMMITTEES

PRESIDENT CARRINGTON: Section XII of the By-Laws authorizes the President to appoint Reference Committees to serve during the session. "To these committees may be referred any report, resolution, measure, or proposition which has been presented to the House. When a matter is referred to any such Committee, it shall meet forthwith, discuss the question referred, hear debates thereon by any interested member of the Society, and shall submit its recommendations at the next session of the House of Delegates for action." (By-Laws, Chapt. VIII, Sect. 12.)

Section XIII of the By-Laws authorizes the creation of Reference Committees on Credentials, Resolutions and Memorials, Constitution and By-Laws, and Miscellaneous Business, and others to be created by the House of Delegates. The Chair will entertain a motion authorizing the appointment of nine additional Reference Committees. The reason for this is the vast amount of committee work done this year, and the multiplicity of our problems. I shall name the personnel of the committees at once.

On motion, the appointment of additional reference committees was authorized, and President Carrington made the following appointments:

REFERENCE COMMITTEES

Reference Committee "OFF" on reports of:

The President
The Board of Trustees
The Executive Officer
The Secretary
Addresses of the President and President-Elect

Walter J. Farr, Chairman Bergen County
Reeve L. Ballinger Hudson
Henry B. Orton Essex
Adolph Towbin Ocean
J. Allen Yager Passaic

Reference Committee "PUB" on reports of:

The Publication Committee
The Sub-Committee on Public Relations
County Society Presidents

James F. Norton, Chairman Hudson County
Marcus H. Greifinger Essex
Baxter A. Livengood Gloucester
Arcangelo Liva Bergen
Bernard C. McMahon Morris

Reference Committee "FIN" on reports of:

The Committee on Finance and Budget
The Treasurer

Edward W. Sprague, Chairman .. Essex County
Henri E. Abel Union
Samuel A. Cosgrove Hudson
Andrew F. McBride Passaic
Saul M. Rubinow Essex

Reference Committee "LAW" on reports of:

The Sub-Committee on Legislation
The Judicial Councilors

David B. Allman, Chairman Atlantic County
William H. Areson Essex
G. Barton Barlow Bergen
George F. Dandois Cape May
H. Garrett Miller Cumberland

Reference Committee "PROG" on reports of:

The Committee on Program and Arrangements
The Sub-Committee on Scientific Program
The Sub-Committee on Scientific Exhibits
The Advisory Committee to the Woman's Auxiliary

Joseph F. Londrigan, Chairman ... Hudson Co.
William H. Long Somerset
William L. Vroom Bergen
John V. Smith Middlesex
H. Burton Walker Cumberland

Reference Committee "WEL" on reports of:

The Welfare Committee

Clarence W. Way, Chairman .. Cape May County
A. Dunbar Hutchinson Mercer
Theodore Thompson Ocean
E. LeRoy Wood Essex
George J. Young Morris

Reference Committee "PH" on reports of:

The Sub-Committee on Public Health
The Advisory Committee on Cancer Control
The Advisory Committee on Venereal Disease Control
The Advisory Committee on Mental Hygiene
The Advisory Committee on Adult Health Supervision
The Advisory Committee on Tuberculosis
The Advisory Committee on Child Health
The Advisory Committee on Maternal Welfare
The Advisory Committee on Crippled Children
The Advisory Committee on Pneumonia Control
The Advisory Committee on Traffic Accidents
The Special Committee on Study of Eugenic Sterilization
The Special Committee on Conservation of Vision

David W. Green, ChairmanSalem County
Frank W. AshPassaic
Jesse McCallSussex
H. Roy Van NessEssex
William C. WilentzMiddlesex

Reference Committee "MP" on reports of:

The Sub-Committee on Medical Practice
The Advisory Committee on Contract Practice
The Advisory Committee on Hospital Relationships
The Advisory Committee on Medical Care of the Indigent
The Advisory Committee on Nursing and Nursing Education
The Advisory Committee on Pharmaceutical Problems
The Advisory Committee on Workmen's Compensation
The Advisory Committee on Auxiliary Medical Services
The Advisory Committee on Industrial Injuries and Occupational Diseases

Herschel S. Murphy, Chairman...Union County
Royal A. SchaafEssex
Daniel A. FeatherstonMonmouth
Henry HaywoodMiddlesex
Charles H. deT. ShiversAtlantic

Reference Committee "INS" on reports of:

The Committee on Medical Defense and Insurance
The Committee on Voluntary Health Insurance

Hilton S. Read, Chairman.....Atlantic County
Vincent P. ButlerHudson
Harry N. ComandoEssex
Donald O. HamblinSomerset
Fred VosburghPassaic

Reference Committee "MISC" to consider:

Miscellaneous Business

J. Lawrence Evans, Chairman..Hudson County
Frank BienEssex
D. Ward ScanlanAtlantic
S. Emlen StokesBurlington
Nathan SwernMercer

SPECIAL REFERENCE COMMITTEES

I. Credentials

Thomas B. Lee, Chairman..Camden County
Elias J. Marsh, ex-officioPassaic
Alfred Stahl, ex-officioEssex

II. Resolutions and Memorials

Hammell P. Shipps, Chm...Burlington Co.
Ellis J. ChapmanHudson
Wayne W. HallPassaic
Ernest G. HummelCamden

III. Constitution and By-Laws

Samuel Alexander, Chairman...Begren Co.
Thomas McG. BrennockHudson
Eugene G. HerbenerOcean
David A. KrakerEssex
Samuel L. SalasinAtlantic

PRESIDENT CARRINGTON: A word about these Reference Committees. They are not created to stifle debate, but to promote free and full discussion. Some of the Reference Committees may be compelled to hold meetings in addition to those scheduled; but extra meetings are hard to publicize, and it is highly desirable that every member of the Society be granted the privilege of free discussion.

The Board of Trustees and the thirty-five committees of the Society have made exceptional contributions. They have prepared their reports in advance. The thirteen Reference Committees have already had time to study these reports.

6. TREASURER'S REPORT

PRESIDENT CARRINGTON: At this time we will hear the report of the Finance Committee, and the first part, I believe, is that of the Treasurer, Dr. Marsh.

Dr. Elias J. Marsh presented the report of the Treasurer. (See next page.)

ANNUAL REPORT OF THE TREASURER

1938—1939

PERMANENT FUND

May 31, 1938—	
4M U. S. Treasury Bonds	\$ 4,045.94
Investors Mortgage & Realty Co.	2,050.00
Trenton Mortgage Service Co.	1,852.75
First National Bank of Paterson sav- ings acct.	7,116.56
	<u>\$15,065.25</u>

May 31, 1939—	
4M U. S. Treasury Bonds	\$ 4,045.94
Investors Mortgage & Realty Co.	1,993.00
Trenton Mortgage Service Co.	1,526.72
First National Bank of Paterson sav- ings acct.	7,499.59
	<u>\$15,065.25</u>

KIPP MEMORIAL FUND

Eye, Ear, and Throat Section

May 31, 1938—	
Deposit, Howard Savings Institution	\$31.05
May 29, 1939—	
Interest on deposit .....	.60
In memory of Dr. Harry S. Willard	5.00
May 31, 1939—	
Deposit, Howard Savings Institution	\$36.65

GENERAL ACCOUNT

RECEIPTS

Balance, May 31, 1938	\$ 54,055.40
Assessment:	

Atlantic	\$ 1,751.00
Bergen	4,013.25
Burlington	772.00
Camden	2,605.00
Cape May	379.00
Cumberland	770.09
Essex	14,601.00
Gloucester	791.00
Hudson	6,231.00
Hunterdon	465.00
Mercer	3,122.00
Middlesex	2,058.00
Monmouth	1,864.00
Morris	1,574.75
Ocean	406.00
Passaic	5,110.00
Salem	392.00
Somerset	799.00
Sussex	322.00
Union	4,517.75
Warren	420.00

52,963.75

Publication receipts	12,042.04
Interest	824.33
Refunds	259.21

\$120,144.73

PAYMENTS

1938 account, unpaid May 31	\$ 846.85
Administration:	
Executive salaries	\$ 9,065.31
Clerical services	5,571.82
Office expenses	1,850.01
Travel	1,394.90
Rent	2,945.34
Finance department	497.41
Secretary's office	223.20
Unemployment compensation tax	1,522.59
	<u>23,070.59</u>

Journal:

Publication	\$14,800.87
Editor, salary and expenses...	5,674.10
Clerical and office expenses...	2,319.22
	<u>22,794.19</u>

Welfare Committee:

Welfare Committee	\$ 1,577.26
Legislation	848.07
Public Health	2,119.98
Public Relations	3,538.49
Medical Practice	1,053.73
	<u>9,142.53</u>

President's office	1,627.44
Legal	1,859.39
Printing	1,692.26
Delegates to A. M. A. (2 meetings)	1,391.88
Pension	1,500.00
Fall Clinical Conference	765.05
Health Survey of the State	612.05
Trustees	829.70
Other agencies	867.85
Annual Meeting, 1939, preliminary	578.70
Furniture and equipment	771.61
Transfer to office cash fund	800.00
	<u>\$ 69,150.15</u>

Balance, May 31, 1939	50,994.58
	<u>\$120,144.73</u>

SUMMARY

Budget appropriations, annual meeting, 1938	\$71,590.00
Appropriated by Trustees from Surplus..	\$ 4,000.00

Receipts	\$66,089.33
Payments	69,150.15

Operation deficit for the year \$ 3,060.82

Cash balance	\$50,944.58
Less 7/12 of 1939 assessment	29,881.85

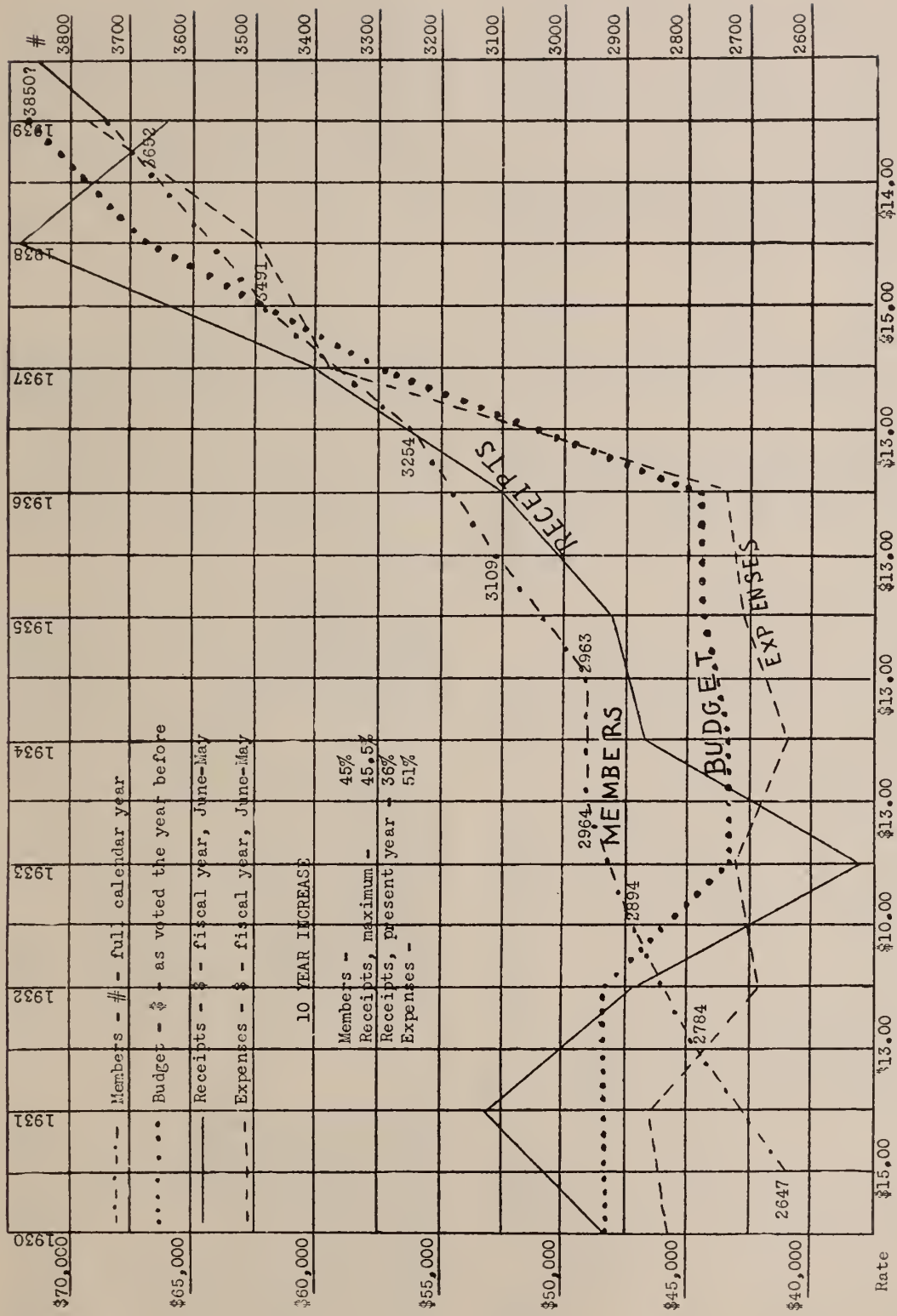
Treasury surplus \$21,112.73

This surplus and certain other items of this report differ somewhat from those in the budget analysis to be prepared by the accountant, being figured on a different basis for a different purpose. The report of the accountant and auditor will be

filed in the Trenton office, where it may be inspected by any interested member.

Attention is called to the attached analytical graph of the Society's finances for ten years past. (See pages 7 and 8.)

Report of Reference Committee, Sect. 39 A.



Summary Chart of Members, Budget, Receipts, and Expenses for the Decade 1930-1939. (See comments, page 8.)

COMMENTS ON THE CHART ON PAGE 7

Beginning in 1930 we had 2,647 paid-up members. The rise in membership has been fairly progressive and we may anticipate that it will reach 3,650 next December.

Between 1934 and 1935 we lost one member. In 1933, when the depression began to pinch, the receipts dropped to a low point of \$36,000; but from that time there has been a rise to the present high point of \$75,000.

Now, the point I have drawn this graph to illustrate is this. Taking the ten-year period, there has been a fairly consistent rise in membership and a drop in the financial situation; but over the period

of ten years the two results are nearly the same. The members have increased 45 per cent in ten years, and the receipts, up to last year, 45.5 per cent. The expenses come a little faster, 51 per cent, and they seemed faster than that, because most of the rise is covered in the last four years. But taking it for the ten-year period as a whole, the rise has been very nearly the same. That is to say, the proportion between the membership receipts and expenses is very nearly the same now as it was ten years ago.

Action, Sect. 39 A.

7. FINANCE COMMITTEE

Dr. Harry R. North, Chairman of the Finance Committee of the Board of Trustees, presented the budget of expenses for the coming year:

Last year, you remember, we had a per capita assessment of fifteen dollars. We reduced it one dollar. At the time, the committee told the members

that was a mistake. Our surplus has dropped from twenty-seven thousand dollars last year, to eighteen thousand dollars this year. We feel that the assessment next year will have to be seventeen dollars.

PRESIDENT CARRINGTON: Those who have questions may present them to Dr. North at 4:30 o'clock before the Finance Committee.

1939-1940 BUDGET

ADMINISTRATIVE AND EXECUTIVE

Salaries—	
Executive Officer—Wilkes	\$7,000.00
Executive Assistant—Scott	4,000.00
	<hr/> \$11,000.00
Salaries and Wages—4 girls and extra help	5,840.00
Office Expenses	1,800.00
Travel (contingent on purchase of automobile)—	
Wilkes	\$1,000.00
Scott	1,000.00
	<hr/> 2,000.00
Rent and Electricity—State Headquarters	2,950.00
Unemployment Compensation (2.7% of payroll)	750.00
Treasurer	125.00
Finance and Budget Committee	50.00
Bonding	90.00
Auditing Expenses	300.00
Secretary—	
Stenographic expenses	\$100.00
Traveling expenses	300.00
Incidental expenses	100.00
	<hr/> 500.00
JOURNAL	
Journal—Publication Committee	14,000.00
Cuts	500.00
Editor's Salary—Overton	5,500.00
Editorial Secretary—	
Salary	\$1,820.00
Overtime (for History)	100.00
	<hr/> 1,920.00
Office Expenses	700.00
Travel—Overton, Editor	250.00

WELFARE COMMITTEE

General Welfare	1,000.00
Welfare Committee	1,200.00
Legislative Committee	3,500.00
Public Health Committee	2,000.00
Public Relations Committee	3,510.00
Medical Practice Committee	1,000.00

SPECIAL ACTIVITIES

President's Fund (including stenographic services)	2,300.00
A. M. A. Delegates (St. Louis meeting in May, 1939)	400.00
Dues—	
Conference Professional Relations	\$25.00
Conference Allied Medical Professions	25.00
	<hr/> 50.00
County Society Officers' Training School	250.00
Clinical Conference	800.00
Woman's Auxiliary (for ad interim activities)	250.00
Voluntary Health Insurance	1,000.00

CONTINGENT

LEGAL

ANNUAL MEETING

Program and Arrangements	1,600.00
Guests	200.00
Art & Hobby & Medical History Exhibit	210.00
Woman's Auxiliary (for annual meeting entertainment)	800.00
Scientific Exhibits	1,000.00

PENSION—Dr. Morrison

PRINTING—Official Transactions and Official List

TOTAL BUDGET 1939-1940

Action, Sect. 39 B.

8. LEGISLATION

(Report, Jour., May, page 281)

Dr. B. S. Pollak, Chairman of the Committee on Legislation, reviewed the status of the progress of the Medical Practice Bill (A-210) in the Senate. Since the report was written the Bill has been passed with slight amendments in which the Assembly has concurred. The Bill is now before the Governor. (The Governor signed the bill on July first, and it is now a law.—Editor's note.)

Action, Sect. 26 A.

9. SUPPLEMENTARY REPORT OF THE WELFARE COMMITTEE

(Report, Jour., May, page 280)

The Chairman of the Welfare Committee, Dr. Hilton S. Read, reviewed the work of the Legislative Committee, which acts under the Welfare Committee.

Action, Section 27.

10. SUPPLEMENTAL REPORT OF THE COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

(Report, Jour., May, page 273)

PRESIDENT CARRINGTON: Dr. Beling, Chairman of the Committee on Medical Defense and Insurance.

Dr. Christopher C. Beling presented the supplemental report of the Committee on Medical Defense and Insurance:

10 A. MALPRACTICE INSURANCE

At the end of the fiscal year, 2,867 members were insured under the special professional liability contract. This is the largest number of doctors insured in any year. There was a gain of 87 new members over the previous year. This number does not include 150 members who were temporarily not in good standing through failure to pay their dues before the publication of the official list. Therefore, the actual number is nearly 3,000. We wish to remind the members again of the importance of the prompt payment of dues to the Society so that their insurance protection is not invalidated.

RATES

The committee has been definitely informed that there will be no increase in the general rates for the coming year unless some unforeseen losses are sustained by the company. The committee takes pleasure in informing the Society that the company, upon request, has made a substantial reduction in the premiums charged for x-ray and radium protection. The reduction in rates was proportionately larger in all the counties excepting Bergen, Essex, Hudson, Passaic and Union. The following is a schedule of the new rates which are now in effect:

X-Ray and Radium Combined or X-Ray Only—New Rates Bergen, Essex, Hudson, Passaic and Union Counties		X-Ray and Radium Combined or X-Ray Only — New Rates Balance of State	
Limits	Rate	Rate	
\$10/\$ 30,000	\$50.00	\$40.00	
15/ 45,000	61.00	48.80	
20/ 60,000	72.00	57.60	
25/ 75,000	77.50	62.00	
50/ 150,000	98.00	78.40	

Radium Only — New Rates Bergen, Essex, Hudson, Passaic and Union Counties		Radium Only—New Rates Balance of State	
Limits	Rate	Rate	
\$10/\$ 30,000	\$31.25	\$25.00	
15/ 45,000	38.12	30.50	
20/ 60,000	45.00	36.00	
25/ 75,000	48.44	38.75	
50/ 150,000	61.25	49.00	

Action, Section 25 A.

10 B. ACCIDENT AND HEALTH INSURANCE

The committee reports that further improvement has been made in the group disability policy of The New Jersey Medical Society. The Insurance Company has lowered the cost, as well as extended the hospital coverage.

The new hospital coverage extension rider is as follows:

A. *Hospital Residence*: Not to exceed \$7.00 per day for the period the assured shall be a resident patient within an incorporated licensed hospital, but not to exceed ten (10) weeks' limit as result of any one disability:

and

Special Fees: Not to exceed \$25.00 limit for necessary service, while confined as a resident patient within an incorporated licensed hospital, as the result of any one disability, as follows: \$10.00 limit for operating room; \$10.00 limit for anaesthesia; \$5.00 limit for x-ray examination (excluding x-ray for teeth).

OPTIONAL COVERAGE (WITH A)

B. For an additional premium of \$4.75 for a total of \$17.25, the coverage for hospital residence and special fees will be further augmented to include nurses' service, as follows: Not to exceed \$5.00 per day for the full-time service of a graduate registered nurse, while confined as a resident patient within an incorporated licensed hospital, not to exceed ten (10) weeks' limit, as the result of any one disability.

The additional premium that will be required for the above coverage on annual, semi-annual or quarterly basis, is as follows:

Coverage	Annual	Semi-annual	Quarterly
A only	\$12.50	\$6.35	\$3.25
A and B.	17.25	8.75	4.50

This new rider is allowed as an option in its entirety to every policyholder, regardless of the size of the policy he carries. Under the provisions of the present rider, the benefits varied according to the amounts carried.

The committee recommends that every member of the Society compare this policy with any policy that he may be carrying at the present time, as to cost and coverage, and if it compares favorably, that he consider seriously supporting the State Society in its endeavors to provide this form of insurance for its membership.

Action, 25 B.

10 C. GROUP LIFE INSURANCE

The committee has made a careful study of this form of insurance and now ventures to present the offer of the Bankers National Life Insurance Company, of Montclair, New Jersey, for the consideration of the Society. There have been some efforts made in the county societies to obtain this form of insurance for the membership, but because of the fact that the insurance companies wanted as least 75 per cent of the members to participate at all times, before they would grant this form of insurance, it has not been feasible to carry it out. The features of this proposition are:

1. It is Term Life Insurance.
2. It is non-cancelable.
3. Without medical examination up to 50 years of age.
4. When 20 members take this insurance up to an aggregate of \$50,000 the plan becomes operative.
5. It is a participating policy with dividend payments, and changes in rate occur every 15 years.

The manner in which this plan can be operated, if it is accepted by the Society, is simple. The premiums will be collected and paid to the Insurance Company by our authorized agent or broker, without any expense to the Society, as in the case of Medical Defense Insurance.

The committee submits herewith the full data on this proposition, including an inquiry into the financial status of the company, and recommends its consideration for the reason that it offers a form of insurance for the protection of the doctor's interests and his estate, at a time when he can ill afford to take out a Straight Life Insurance Policy to the extent that he would be able to later in his career.

In conclusion, the committee desires to thank both the Insurance Companies and the official agents for the coöperation extended during the year, and also thanks the various county committees for their coöperation in advancing the program of the State Society. The committee recommends to the Society that it strongly urge every one of its members to obtain their protection through the agencies that were set up by the Society.

Action, Section 25 C.

GROUP LIFE INSURANCE

The Society has learned that Group Life Insurance in associations is not practicable. First of all,

insurance companies cannot freely offer the plan as State statutes must be observed. Then too, it has been demonstrated that it is next to impossible for associations to guarantee at least a 75 per cent participation in the plan by the members, at premiums which are determined by the average age and the future experience of the case.

The committee has learned, however, that other associations, such as the New Jersey Funeral Directors Association, the New Jersey State Dental Society, the Newark Teachers Association, as well as component societies of the A. M. A. and the A. D. A. and affiliate fraternities have been able to qualify for a plan very similar to Group Life Insurance written legally as individual life insurance in groups.

This plan, now outlined, permits our members and members of their families as well (wives and children) to apply for life insurance at very low rates. The plan offered by the Bankers National Life Insurance Company of Montclair, New Jersey, is legal reserve term life insurance at a premium that remains the same for fifteen years and at the end of that term, if the insured is not over sixty, it is automatically extended for other fifteen-year periods at increased premiums. At age 35 the insured member pays \$5.02 for six months for \$1,000 of insurance. At age 50 his premium is \$11.39 for six months for the ensuing period, with privilege of further renewal after that subsequent fifteen-year period. Persons now over 60, or who become over 60 at the beginning of any new fifteen-year period may join at the Yearly Renewable Rate scheduled on this sheet.

Age at issue of policy determines the maximum amount of insurance allowable (minimum is \$1,000 for all ages):

10 to 14	\$1,000	51 to 60	\$3,000
15 to 50	5,000	61 to 65	1,000

No medical examination is required of applicants for \$3,000 or less, who are under 50 years, whose application offer satisfactory evidence of insurability.

Each insured person receives an individual policy. This policy provides for automatic conversion to some other plan of insurance of the company at the cessation of the insured's membership in the Society. As dividends are earned by the group they will be paid to the Society.

Under this plan the company does not ask for the usual 75 per cent participation by the members. The plan will be operative as soon as applications are received and accepted by the company from only twenty persons for a total of only \$50,000 of insurance. This is the sole qualifying requirement, and it will be seen that an agreement can be very easily entered into as \$50,000 of insurance can be secured without any delay.

The plan and the insurance company have both been thoroughly investigated by the committee. The company is incorporated under the laws of the State of New Jersey, and this exclusive plan, Blanket Coverage Insurance, has been successfully sold by that company for a number of years.

The Insurance Committee desires to learn how many of the Society's members and their family members would be interested in joining the group for insurance. The attached questionnaire when completed and returned, will enable the committee to continue its negotiation with the Insurance Company with full knowledge of the Society's feeling about life insurance which they can get at better than individual rates.

The Insurance Committee,
C. C. BELING, *Chairman*.

11. COMMITTEE ON PUBLIC RELATIONS

(Report, Jour., May, page 311)

Dr. Joseph H. Kler, Chairman of the Committee on Public Relations, read the supplementary report of that committee, which was in the form of the following resolution:

Whereas, newspapers of New Jersey, New York City, and Philadelphia have consistently performed a public health function by according a generous amount of space in their news columns to matters relating to health; and

Whereas, the Newark Evening News has coöperated with this Society in its public education program by publishing as a feature of its Saturday issue each week the column on "The Story of Modern Medicine", written by members of the Essex County Medical Society; and

Whereas, for many years the Newark Evening News has assigned a staff correspondent to attend the annual convention of The Medical Society of New Jersey; and

Whereas the Atlantic City Press has also published a special Health Section during the convention dedicated to The Medical Society of New Jersey; and

Whereas, the correspondents assigned to report the activities of the Medical Society have invariably presented an accurate résumé of the events of the annual convention;

Therefore, be it resolved, that the House of Delegates of The Medical Society of New Jersey goes on record as expressing its appreciation of the fine type of journalism manifested by these and their newspapers in their splendid efforts to keep their readers fully informed concerning health and medical matters.

For action on the revised form, see Sect. 23 B.

12. HOSPITAL RELATIONSHIPS

(Report, Jour., July, page 415)

Dr. Spencer T. Snedecor, Chairman of the Committee on Hospital Relationships, referred to the supplementary report which was printed in the July Journal, page 415, and was distributed in the form of reprints to this House of Delegates.

Action, Sect. 40 J.

13. SECRETARY'S SUPPLEMENTARY REPORT

(Report, Jour., May, page 266)

Secretary Stahl read the following supplementary report:

Your Secretary attended the sessions of the House of Delegates at the Statler Hotel, St. Louis. The sessions were conducted most harmoniously, and definitely in a democratic manner. The Medical Society of New Jersey was eminently and actively represented by its four Delegates: Dr. Andrew F. McBride, Dr. Wells P. Eagleton, Dr. Hilton S. Read and Dr. Lucius F. Donohoe. Dr. William J. Carrington, President; Dr. Spencer T. Snedecor, Dr. LeRoy A. Wilkes and your Secretary also attended the sessions of the House of Delegates. All told, forty-eight Fellows were registered from New Jersey.

The item of greatest importance before the House of Delegates was the consideration of the so-called Wagner Health Bill. The Reference Committee, after long and arduous consideration, presented its report, which was a masterpiece, and was adopted by the House of Delegates without a dissenting vote. In essence, this report opposes unqualifiedly the Federal-controlled national health program contemplated in the Wagner Bill. The report favors development, within the philosophy of the American form of government, of a program that will insure adequate and efficient medical care for all. A detailed analysis of the Wagner Health Bill appeared in full in the March 11th issue of the A.M.A. Journal, page 999.

The House of Delegates of the A.M.A. selected Atlantic City for the 1942 convention. For this we are indebted to Dr. Andrew F. McBride, who eloquently set forth the many unequaled advantages of Atlantic City as a preeminent convention city.

Dr. Nathan B. Van Etten, of New York, was elected President-Elect, and Dr. Alphonse McMahon, of St. Louis, was elected Vice-President.

Respectfully submitted,

ALFRED STAHL, M.D., *Secretary*.

14. REPORTS OF A. M. A. DELEGATES

PRESIDENT CARRINGTON: Since the annual meeting of the American Medical Association in San Francisco on June 13-17, 1938 (Journal, June, 1938, p. 439) there have been two meetings of the A. M. A.:

First: A special meeting on September 16 and 17, 1938 (Journal, October, 1938, p. 614).

Second: A regular annual meeting in St. Louis on May 15-19, 1939.

14 A. DR. A. F. MCBRIDE'S REPORT ON MEDICAL EDUCATION AND HOSPITALS

Permit me to report briefly on the action of the House of Delegates of the American Medical Association with regard to recommendations made and hearings held by the Reference Committee on Medical Education and Hospitals. (Jour., A. M. A., May 27, pp. 2166 and 2170.)

In 1904 the American Medical Association created the Council on Medical Education, which is responsible to the House of Delegates elected by the State medical societies. The Committee on Medical Education and Hospitals is the group of delegates whose particular interest is the work of the Council. The Council is bending its every effort towards the goal of achieving the proper selection of candidates for medical education, the best training of these candidates in the medical school and in the hospitals, and the provision of opportunities for the practitioner to keep abreast of new developments. The presenting problem at the moment is the coördination of the various agencies which have dealt with these problems in the past, so as to eliminate duplication of effort, and other sources of confusion and possible inefficiency. At the same time it hopes to anticipate needs which are not covered by existing agencies. In short, while recognizing the various contributions to elevation of medical standards of the American College of Surgeons, the American Surgical Association, the Association of American Medical Colleges, the Federation of State Medical Boards, and the National Board of Medical Examiners, and the various specialty boards—to name a few—it is felt that some coördination of their efforts would make for less confusion. In this belief the Committee on Medical Education and Hospitals concurred, and a motion to that effect was approved by the House of Delegates.

In this same connection the committee recommended that the Council be enlarged from seven, to nine members; that tenure of office be extended to nine years; and that the right of succession be withheld. The feeling of the committee in this regard was that coördination of the various branches dealing with pre-medical, medical, and post-graduate education involves such a wide group that an enlarged Council would insure better representation of all concerned. The recommendation was approved.

Another matter of significance which came up for discussion was the laxity of the present restrictions on the use of radium and radium emanations. It was brought to the attention of the committee by several specialists that radium was available to persons not trained in its use through private and commercial agencies. It was the opinion of our committee that some tightening of the present loose regulations on the distribution of radioactive substances is desirable.

14 B. DR. W. P. EAGLETON'S REPORT ON THE WAGNER BILL

Dr. Eagleton described the hearing on the Wagner Bill and the twenty-two points of the conclusion of the committee as described in the A. M. A. Journal of June 3, pp. 2295-2297.

Dr. Eagleton also introduced the following motion:

Resolved, that The Medical Society of New Jersey instruct its delegates to the A. M. A. to call for, and try to secure:

1. An ad interim meeting of the House of Delegates of the A. M. A. annually, to be devoted solely to the formulation of medical policies; and

2. Measures to give the House of Delegates proper authority to enforce its will and decrees having control of its own money.

PRESIDENT CARRINGTON: This resolution has been seconded and is referred to the Committee on Resolutions.

Action, Sects. 42 and 42 A.

14 C. A. M. A. DELEGATE DR. H. S. READ

Dr. Hilton S. Read, Chairman of the Welfare Committee and one of the A. M. A. Delegates, gave a description of the inside workings of the hearing before the A. M. A. committee on the Wagner Bill. He said that considering the short time for investigation and formulation of conclusions, the report of the committee seemed to be as broad and definite as could be expected.

14 D. A. M. A. DELEGATE DR. LUCIUS F. DONOHUE

Dr. Donohue gave the following written report on the participation of The Medical Society of New Jersey in the A. M. A. survey:

New Jersey's participation in the A. M. A. Survey of Need and Supply of Medical Care was acknowledged by A. M. A. as the most complete and best in the form of presentation.

This report has done much to convince the A. M. A. of the earnest desire of The Medical Society of New Jersey to follow constructive leadership of A. M. A. when such leadership is shown.

The report covers all twenty-one counties and was compiled by the component county societies and the Executive Staff of the State Society with the help of all State agencies whose data was solicited. The data was presented in the form requested by the A. M. A., and this presentation was supplemented by data which did not fit in with the form suggested by A. M. A. but which we felt would better inform those studying the report of the conditions and needs of New Jersey, and the extent to which these needs were effectively met by the personnel and facilities in New Jersey.

Copies of the State Survey and of the twenty-one counties' survey reports are on exhibit opposite the Office of the Executive Officer.

15. BERGEN COUNTY DELEGATES

SECRETARY STAHL: At this time I should like to say that Bergen County sent twenty-one names with its check, postmarked March 15, and it was therefore not entitled to delegates representing them. I should like to make a motion that these two delegates to which they are really entitled, be seated.

On motion, the Bergen County Delegates were seated.

16. REPORT OF COMMITTEE ON VOLUNTARY HEALTH INSURANCE

Dr. Elton W. Lance, Chairman of the Committee on Voluntary Health Insurance, gave the following report:

A consideration of Voluntary Health Insurance was started by The Medical Society of New Jersey in October, 1938, by the appointment of a fact-finding committee under the chairmanship of Dr. Hilton S. Read. After rendering a report in December, 1938, the committee was dissolved and a new committee headed by Dr. Edward Sprague continued the investigation and reported in January, 1939.

The present committee, since April, 1939, has acted as a founding committee.

After due consideration and consultation with legal and actuarial authorities, the committee wishes to recommend the following procedure for the control and administration of a Medical Service Plan for New Jersey:

First—That the Board of Trustees of The Medical Society of New Jersey appoint not less than three physicians from the Society as Trustees to form a non-profit corporation under an act of the legislature approved April 21st, 1898, for the purpose of formulating and administering a voluntary, non-profit plan.

Second—That the corporation shall have a sum not to exceed \$5,000.00 appropriated from the treasury of the State Society to finance its initial expenses.

Third—That any plan inaugurated by the corporation shall be considered experimental for one year only.

Fourth—That the corporation shall operate the plan in a limited area only, during the first experimental year.

Fifth—That the plan shall be designed on a non-profit, voluntary basis, and shall preserve patient-physician relationship as enjoyed at present.

Sixth—The committee further recommends that the details of executing the plan be placed in the hands of the Board of Governors, which are to be appointed by the State Society.

Seventh—The committee has developed basic principles which it believes should govern the plan, and wishes to offer these to the new Board of Governors to assist them in the final formation of a plan.

The committee wishes to present:

1. A letter from Mr. Wall, our attorney, explaining the legal status and possibilities of a plan.
2. A copy of "Certificate of Incorporation".
3. A copy of a resolution to be read before the House of Delegates.

MR. WALL'S OPINION

The enclosed Certificate of Incorporation is drawn under the 1898 Law which applies to corporations not for pecuniary profit. It is the act used for clubs and certain charitable corporations. Corporations formed under it have no capital stock.

The purposes are stated in Clause II. They follow the purposes outlined by your committee. The scheme is to furnish medical and surgical services to selected low-income groups by competent practitioners.

The fees for services are to be fixed by the Plan to be adopted by the Board of Governors of the corporation.

The Medical Society of New Jersey has no connection with the new corporation beyond the fact that the Society will appoint the Governors of the new corporation.

Intrinsically this is a method whereby a number of selected doctors get together and agree to treat selected patients at a fixed yearly fee which will be less than such patients are required to pay for unexpected accidents and diseases occurring in the ordinary course. The design is to preserve the present patient-physician relationship and diminish the economic hazard of a certain low-income group. It is not a charity.

The only difference between it and any association of doctors who treat patients for a definite fee is that it shall not be for pecuniary profit and the Governors shall be appointed by the Medical Society. What the Plan, as adopted, may be will be determined by the Board of Governors. Their aggregate wisdom shall be the rule of the corporation. Hence it is free; government has no part in its control. It is as individualistic as the present relation between doctor and patient. It has the advantage that it is experimental; if it fails no harm will ensue.

The other alternative is to have a law passed somewhat similar to Chapter 366 of the Laws of 1938 in reference to Hospital Service Plans. Such a law must be comprehensive. It must specify the Plan. Many plans are being considered by the country at large. The question is a new one in our civilization, and it may be doubted whether the physicians in this State are ready to give adherence to any particular plan. If they do, and the plan does not work, it will be very difficult to undo it. I should think that the choice of three trustees under the experimental Plan would be in accordance with the maxim, "Pick a good man and trust him".

I enclose also a draft of a Resolution, as a suggestion, to be passed by the Medical Society if the Trustees approve.

Very truly yours,

(Signed) ALBERT C. WALL.

CERTIFICATE OF INCORPORATION OF THE MEDICAL SERVICE PLAN OF NEW JERSEY

This is to certify that we, the undersigned, do hereby associate ourselves into a corporation under and by virtue of the provisions of an Act of the Legislature of the State of New Jersey entitled "An Act to incorporate associations not for pecuniary profit", approved April 21st, 1898, and the several supplements thereto and acts amendatory thereof.

I. The name or title by which the corporation is to be known in law is "*The Medical Service Plan of New Jersey*".

II. The purposes for which it is formed are:

a. To assist a selected low-income group of persons to secure medical and surgical care, including preventive measures, diagnosis and treatment by fully qualified physicians.

b. To accomplish the above purposes by the establishment of a plan on a non-profit, voluntary basis which preserves the present patient-physician relationship by allowing the free choice of physician and patient.

c. To do all such other things as are incidental or conducive to the attainment of the above purposes.

III. The place where the corporation is to be located and its activities conducted is ———.

IV. The number of Trustees, which shall not be less than three, and the names and post office addresses of the Trustees selected for the first year of the corporation's existence are:

Name:	Residence:
.....
.....
.....
.....

V. The corporation may have an office outside of the State of New Jersey for the convenience of its officers and Trustees and where meetings of the Trustees may be held at such places as may be determined by its Trustees.

VI. The Trustees (hereinafter called the Board of Governors) shall be appointed by the Board of Trustees of The Medical Society of New Jersey. After the first year of the corporation's existence the Board of Governors shall consist of eight members, five of whom shall be members in good standing of The Medical Society of New Jersey.

VII. The Board of Governors shall serve the corporation without pay.

The funds of this corporation shall be expended only for the purposes set forth in this certificate and in the By-Laws to be adopted in accordance therewith, and no funds shall be distributed in the form of dividends.

Dissolution shall be pursuant to the provisions of the Corporation Laws of New Jersey.

VIII. The corporation shall maintain an office in the State of New Jersey at No. ——— Street, in the County of ———, and ——— shall be the registered agent in charge of such office upon whom process against the corporation may be served.

In witness whereof, we have hereunto set our hands and seals the ——— day of ———, 1939.

STATE OF NEW JERSEY, }
COUNTY OF ———. } ss:

Be it remembered, That on this ——— day of ———, 1939, before me, ——— personally appeared ———, ——— and ———, whom I am satisfied are the persons named in and

who executed the foregoing certificate; and I having first made known to them the contents thereof, they did each acknowledge that they signed, sealed and delivered the same as their voluntary act and deed for the uses and purposes therein expressed.

The committee offers the following resolution:

Resolved, That the Board of Trustees of this Society are authorized and directed to appoint three members in good standing of The Medical Society of New Jersey for the purpose of filing a Certificate of Incorporation under the provisions of an Act of the Legislature of the State of New Jersey entitled "An Act to incorporate corporations not for pecuniary profit", approved April 21st, 1898, and the several supplements thereto and acts amendatory thereof.

The name of the corporation is to be "*The Medical Service Plan of New Jersey*", and the purposes for which it is to be formed are:

a. To assist a selected income group of persons to secure medical and surgical care, including preventive measures, diagnosis and treatment by fully qualified physicians.

b. To accomplish the above purposes by the establishment of a plan on a non-profit, voluntary basis which preserves the present patient-physician relationship by allowing the free choice of physician and patient.

c. To do all such other things as are incidental or conducive to the attainment of the above purposes.

Subsequent to the first year of the corporation's existence the Trustees (called the Board of Governors in the certificate to be filed) shall be appointed by the Board of Trustees of The Medical Society of New Jersey. They are to consist of eight members, five of whom shall be members in good standing of The Medical Society of New Jersey.

The corporation to be formed shall have no capital stock, and the Trustees shall serve without pay. All funds paid in by the subscribing patient-members shall be first devoted to the expenses of the corporation in the administration and management of any plan which may be adopted; and second, to the doctors and surgeons who perform services to the subscribing patient-members.

Dissolution of the corporation shall be in accordance with the Corporation Laws of New Jersey.

Be it further resolved that the Board of Trustees approve of subsidizing this new corporation by The Medical Society of New Jersey in the form of a loan, not to exceed \$5,000.

PRESIDENT CARRINGTON: The report and the resolution are referred to Reference Committee "INS".

Action, Sects. 25 D, and 25 E.

17. PRESCRIPTION PHARMACIES IN DEPARTMENT STORES

(Report, Journal, May, page 291)

Dr. Chester I. Ulmer presented the following resolution on the establishment of prescription pharmacies in department stores:

Whereas, Proper and adequate medical care includes a professionally supervised supply of drugs and medicines at all times; and

Whereas, The compounding and dispensing of physicians' prescriptions are carefully regulated under the Pharmacy Laws of New Jersey; and

Whereas, The issuance of permits to conduct prescription pharmacies is limited under the New Jersey Pharmacy Laws to establishments capable of giving complete professional services and considered by the Board of Pharmacy to be fully qualified as to equipment, personnel and facilities to render such complete services; and

Whereas, There is a tendency on the part of commercial organizations of the department store type to acquire the right to practice various professions concerned with medical care by engaging members of the professions concerned and placing them under the supervision of laymen; now, therefore be it

Resolved, That The Medical Society of New Jersey in convention assembled, expresses its disapproval of the introduction of prescription pharmacies by department stores and similar commercial organizations, on the ground that such services in establishments of this character cannot be available at all times, and are bound to be without the intimate professional control essential to their full efficiency.

CHESTER I. ULMER, M.D., *Chairman*,
Committee on Pharmaceutical Problems.

This resolution was referred to Reference Committee on Resolutions and Memorials.

For action, see Section 28 C.

18. FOOD AND DRUG ACT

Dr. Norman W. Burritt submitted the following resolution on the Food and Drug Act:

PREAMBLE

Controversies concerning social changes can become so garbled, especially lacking the opinions of experts, that real issues are never met. Such, for instance, is liable to be the outcome of the National Medical Conference with the biased expressions of the conferees. No true factual data were produced. Such also can become discussions of Pure Food and Drug Control unless there is willingness to produce facts.

An instance demonstrating what can be accomplished by influence without veritable data, is the tremendously important financial collapse of McKesson & Robbins.

Now here are two facts that are veritable. In 1934 the Federal Department of Banking and Finance in the Senate was apprised of the false inventory of drugs of McKesson & Robbins. A letter

from that committee states that an investigation would be held. There is no record of such investigation.

In 1935 a member of the Food and Drug Administration, in the presence of the Welfare Committee of The Medical Society of New Jersey, was read a list of the numbers of the records, under his administration, of violations unpunished, by McKesson & Robbins, Burke & Company, Libby, McNeil & Libby and Swift & Company (Land o' Lakes butter). This member of the administration was asked for an explanation. The only explanation we saw was a red face. And up to the present moment, inquiries by Mr. Charles M. McNery of the Department of Justice have received no reply from any member of the Food and Drug administration concerning the reason for these particular deficiencies.

Here are some more interesting data. At the annual meeting of the State Medical Society, Reference Committee E read a report from the Board of Trustees concerning the investigative work which had been prosecuted in the name of The Medical Society of New Jersey concerning Food and Drug Law enforcement. The report of the Reference Committee E terminated by saying, "We strongly urge the incoming President to continue this work." This report was adopted by the House of Delegates.

During this past year on two occasions a member of the Welfare Committee offered a resolution to that body requiring the President to appoint a committee to continue to study Federal Food and Drug Law investigation. On neither occasion was the resolution allowed to be presented to the committee for a vote, but head noddings on the platform seems to indicate that the officials understood, and would comply. There is still purposeful confusion being injected into discussions on the part of administrators, legislators, commercial groups and misguided women's organizations, and even into the councils of both this State Medical Society and the American Medical Association. I think, and you think (or you should think) it is time to desist discussions of personalities and to climb down from the heights of theoretical discussion and examine documentary data—if the officials of the Federal Government can be persuaded or forced to produce the data.

If there had been an explanation of the unpunished violations by McKesson & Robbins, as well as others; if there was any explanation for the similar unpunished violations recorded in the annual reports of the chief of the Food and Drug administration, which were the subject of a special investigation by a committee of the Board of Trustees just a year ago, surely it would be wiser for the officials of the administration to make that explanation in writing rather than to descend to writing attacks on either the Medical Society or the members who have sought only investigation under oath. Such was the nature of the report of the Board of Trustees one year ago. The Reference Committee which reviewed the report of the Board of Trustees and the House of Delegates, which passed on that Reference Committee's report, considered that the subject was of sufficient importance to make formal recommendation that the Presi-

dent see that the work that had been going on continue, and now an explanation of a reason for disregarding that action seems to be in order.

So that there will be no mistake, and no possibility of miscarriage, I should like to offer a resolution:

That the House of Delegates of The Medical Society of New Jersey instruct the President, for the year beginning, and expects the succeeding Presidents to see to it that the work of investigation of the Federal Food and Drug administration continues and is prosecuted as a part of the regular program of the Society.

(Signed) N. W. BURRITT, M.D.

PRESIDENT CARRINGTON: This report will be referred to the Committee on Resolutions and Memorials.

Action, Sect. 28 E.

19. CREDENTIALS OF NOMINATING COMMITTEE

SECRETARY STAHL: According to the Constitution, the members of the Nominating Committee are to present their credentials at this time.

The personnel of the Nominating Committee was printed in the June Journal, page 387.

The first session of the House of Delegates adjourned at 4:30 o'clock.

Wednesday Noon, June 7, 1939, Second Session

The Second Session of the House of Delegates convened on Wednesday noon, June 7, 1939, with President Carrington presiding, for the special purpose of electing officers.

20. REPORT OF THE NOMINATING COMMITTEE

The House of Delegates, proceeding according to parliamentary rules, received from the Nominating Committee the following nominations for officers for the coming year:

For President-Elect, Dr. Watson B. Morris, Springfield

For First Vice-President, Dr. Thomas K. Lewis, Camden

For Second Vice-President, Dr. Elias J. Marsh, Paterson

For Treasurer, Dr. George J. Young, Morristown

For Councilors:

First District, Dr. Christopher C. Beling, Newark

Second District, Dr. S. Emlen Stokes, Moorestown

Trustee from the Third District, Dr. Harry R. North, Trenton

Trustee from the Fourth District, Dr. Thomas B. Lee, Camden

Trustee from the Fifth District, Dr. Ralph K. Hollinshed, Westville

Delegates to the American Medical Association for two years:

Dr. Andrew F. McBride, Paterson

Dr. Lucius F. Donohoe, Bayonne

Alternates to the American Medical Association:

Dr. Spencer T. Snedecor, Hackensack

Dr. Ralph K. Hollinshed, Westville

Dr. Elmer P. Weigel, Plainfield

For Member of the Publication Committee, Dr. Henry C. Barkhorn, Newark

No other nominations having been made for these offices, a ballot was taken and the nominees were unanimously elected.

21. ELECTION OF TRUSTEE FOR THE SECOND DISTRICT

The House of Delegates proceeded to elect a Trustee for the Second District to succeed Dr. Frederic J. Quigley, whose term of office has expired.

The Nominating Committee nominated Dr. James F. Norton, Jersey City.

Dr. Andrew F. McBride nominated Dr. Frederic J. Quigley, Union City, to succeed himself.

The Chair appointed Drs. Sprague, Ballinger, and Burkett tellers of election.

A ballot being taken, President Carrington announced that Dr. Norton, having received a majority of votes cast, was elected Trustee from the Second District.

This completed the election of officers, which was the only order of business for the session.

The Second Session of the House of Delegates then adjourned.

Third Session of the House of Delegates, Wednesday, June 7, 1939, at 2:45 o'clock

The House of Delegates reconvened at 2:45 o'clock on Wednesday, June 7, 1939, President Carrington presiding.

22. INTRODUCTION OF VISITING DELEGATES FROM OTHER STATE SOCIETIES

The following visiting delegates from other State Societies were introduced, and were received by President Carrington with gracious words of welcome:

New York, Dr. Terry M. Townsend, New York City, President, Medical Society of the State of New York.

Dr. Townsend said in his response:

It is a delight to be here with you, and it is a further delight to think of a rejuvenation of the friendship which has so many years existed between our neighboring states, and I hope that all future meetings, both of ours and your State, will be graced by someone who thinks enough of our organization to be present and present the fraternal greetings of his own State.

Connecticut, Dr. James R. Miller, Hartford, Treasurer

Dr. Oliver L. Stringfield, Stamford.

Dr. Miller, responding, said:

We have just installed a system whereby we have raised our dues from eight dollars to fifteen dollars for the purpose of securing the full-time services of our efficient Secretary, Dr. Creighton Barker, from whom I am sure we will hear and you will hear good things later.

We have legalized the hospital insurance business in Connecticut. The State Medical Society has put in a medical service plan enactment which is probably going through today. Medical licensure has received our care and we are not quite sure whether full citizenship is going to be required for examination for all of those who participate in the healing arts. The Governor is going to appoint a Commission of five to look into the needs for medical care in the State. That idea, of course, was not entirely spontaneous with the legislature, but it germinated in our efficient Secretary's mind.

Perhaps one of the most practical suggestions that I might leave with you is what has happened in connection with our State Journal. The Connecticut Hospital Association has made our State Journal its official organ. The hospital people and doctors are dealing with the same problems and should play ball together, and I might add that the hospital people can bring along to our Journal a considerable amount of profitable advertising which will help financially.

23. INSTALLATION OF PRESIDENT,

DR. EDWARD ZEH HAWKES, NEWARK

Dr. Royal A. Schaaf, President of the Essex County Medical Society, introduced President-

Elect Edward Zeh Hawkes, of Newark, who had been made President-Elect by the House of Delegates in the 1938 meeting. Dr. Schaaf described Dr. Hawkes in a friendly, intimate manner, and enumerated the following characteristics which ensured his success as President:

1. A vigorous, alert, discerning, and youthful mind.
2. Administrative ability of a high order.
3. Skill and experience in parliamentary procedure.
4. Forethought and foresight.
5. Courage.
6. Tenacity of purpose.
7. Fairness and impartiality.
8. Rigid honesty.

Dr. Schaaf continued:

Under his leadership the welfare of The Medical Society of New Jersey is assured. It is my happy privilege to present the incoming President, the pride of Essex County, Dr. Edward Zeh Hawkes.

The assembly arose and applauded.

Dr. Hawkes then gave the address which is printed on page 449 of the July Journal.

24. AWARDS OF MERIT

PRESIDENT CARRINGTON: I have the report of an anonymous committee which I will now read:

To Dr. Carrington, President, The Medical Society of New Jersey:

Your committee was appointed with the approval of the Board of Trustees to select men outstanding in our Society under the following captions:

1. Civic Service.
2. Contributions to the Public Health of New Jersey.
3. Humanitarianism.
4. Contributions to the Progress of Scientific Medicine.

The committee makes the following recommendations for special awards of this Society:

For Civic Service, to Dr. Andrew F. McBride, Paterson.

For his activities as Mayor of Paterson, New Jersey, for six years, during which time he gave that city his services and an administration which was outstanding in its honesty and achievements; for his services as Commissioner of Labor, during which he so conducted his activities as to reflect credit not only to himself but to the medical profession at large, we recommend Andrew F. McBride, of Paterson, New Jersey.

For Contributions to Public Health, to Dr. Stanley Nichols, Asbury Park.

For his work as a member of the State Board of Health; for his activities in preventive medicine, especially among children; for his labors in integrating the various activities of the State Society with the various welfare agencies of the State, our award is given to Stanley Nichols, of Asbury Park, New Jersey.

For his Humanitarianism, to Dr. Berthold Pollak, Hudson County.

For his work among the tuberculous, not only of his own county, but to the State and nation; for the reflected credit accruing to our State Society from his altruistic activities, our award is given to Berthold Pollak, of Hudson County.

For Contribution to the Progress of Scientific Medicine, to Dr. Edward J. Ill, of Newark.

As a pioneer surgeon of New Jersey, his reputation for ability, surgical judgment, and honesty of purpose, is international for his original work in the operative treatment of cancer and for his contributions to the alleviation and cure of many gynecologic problems and for the esteem in which he has been held by the profession of New Jersey, our award is given to Edward J. Ill, of Newark.

The committee closed its report with the following suggestions for future awards:

Your committee, the personnel of which it seems best to keep secret, appointed to select men from our Society for special award, submits the following suggestions:

1. That the standard for selection be based on the following:
 - a. Civic Service.
 - b. Contributions to the Public Health.
 - c. Humanitarianism.
 - d. Contributions to the progress of scientific medicine.

We further suggest that this committee be appointed by the Chair for a period of either three or five years, since we feel that a committee so appointed can more efficiently survey the membership for these awards.

25. REPORT OF REFERENCE COMMITTEE "INS"

(Report, Jour., May, page 273)

Dr. Hilton S. Read, chairman, stated that the committee considered the reports of three subjects in the report of Dr. Beling.

1. On Medical Defense.
2. On Voluntary Health Insurance.
3. On Group Life Insurance.

25 A. Dr. Read made the following report on Medical Defense (Section 10 A):

Your Reference Committee "INS" has carefully studied the very excellent report of the Committee on Medical Defense and Insurance. This committee, under the able chairmanship of Dr. Christopher

C. Beling, goes on from year to year quietly rendering a distinct service to The Medical Society of New Jersey that should not go uncommended.

The report was in two parts. That having to do with special professional liability insurance, in common parlance, *malpractice insurance*, shows that through the diligent efforts rates have been kept as low as possible and benefits increased. We approve this portion of the report.

On motion, this part of the report was approved.

25 B. Dr. Read made the following report on Accident and Health Insurance (Section 10 B):

The second part of the report has to do with *accident and health* insurance. We approve the continued participation of the members of the State Society in this activity, and urge a more active interest in this type of insurance by the county societies and the individual members, through the approved company that has coöperated so well with the Society in the past. We approve this portion of the report.

On motion, this section of the report was approved.

25 C. Chairman Read made the following report on Group Life Insurance (Section 10 C):

In a supplementary report made by Dr. Beling, a third item is considered, namely, *blanket coverage lift insurance*, or what is known as *group life insurance*. We appreciate the time and effort that this committee has spent in studying this subject, but we believe that this is a matter, as has been demonstrated in some isolated efforts among the county societies, that should be left to the individual, and not to the group. We do not approve the State Society participation in group life insurance for its members.

On motion the House concurred in the proposition of the Reference Committee that the report of the Sub-Committee on Group Life Insurance be *not* approved.

25 D. Chairman Read read the report of the Reference Committee on the report of the Committee on Voluntary Health Insurance, setting forth its Medical Service Plan, as follows:

(From Section 16)

Your Reference Committee "INS" had the pleasant task of reviewing the very excellent report of the Committee on *Voluntary Health Insurance*, which report was made available to the Delegates yesterday. Your committee appreciates the wise counsel and generous coöperation that was made available at the hearing by the Delegates from Connecticut

State Society and the New York State Society, as well as the advice of the members of the committee and other members of the State Society who appeared before us.

We approve the seven general principles as outlined in that report. We approve the letter from our Counsel, Mr. Wall, as well as the suggested certificate of incorporation proposed by Mr. Wall. We approve the resolution as submitted in that report.

On motion this report of the Reference Committee was approved.

25 E. Chairman Read also read an additional report on Voluntary Health Insurance, as follows (from Section 16):

Your committee feels impelled to call your attention to the fact that The Medical Society of New Jersey was one of the first societies to investigate voluntary health insurance, which study has been ably and carefully conducted by the committee under the chairmanship of Dr. E. W. Lance.

It would perhaps bear repetition that considerable power is delegated to the Board of Governors; but it is done with full knowledge and the strong belief that our own members who are so selected and who choose to make the sacrifice will impartially protect the rights of the physicians in New Jersey and the consumers of medical care. Perforce no absolutely final mechanical plans and figures can at this time be submitted for your approval. The plan itself, we believe, offers as good a chance of success and as little chance of error as reasoned caution permits. We were early in the field, but we did not dive precipitously and we hope to benefit by the mistakes of others. It is an effort to avoid pauperism, and an answer to provide medical care among a group that so badly needs it. It will perforce contain a fee schedule something like the E. R. A. and by the same token it will have to have a ceiling of eligibility. It is the approval of the philosophy that is important. We must trust the operation to our trusted colleagues.

DR. READ: The resolution embodied in Section 16 enables the plan to be put into operation and we urge its adoption. I move the adoption of that portion of the report.

The motion was regularly seconded, was put to a vote, and was carried.

DR. READ: I move the adoption of the report as a whole.

The motion was regularly seconded, was put to a vote, and was carried.

DR. READ: The report is respectfully submitted, and signed by the members of the committee. I now move the adoption of the resolution with the enabling resolution.

The motion was regularly seconded, was put to a vote, and was carried.

PRESIDENT CARRINGTON: Your Reference Committee is adjourned, sine die, unless some unusual circumstance should arise.

26. REPORT OF REFERENCE COMMITTEE "LAW"

(Report, Jour., May, page 281)

PRESIDENT CARRINGTON: Dr. Allman, are you ready to report for the Reference Committee "LAW"? This committee has to do with the reports of:

1. The Sub-Committee on Legislation.
2. The Judicial Councilors.

26 A. SUB-COMMITTEE ON LEGISLATION

(Report, Section 9)

Dr. Allman submitted the following report: We are pleased to note the commendable work of the Committee on Legislation. We feel that too much praise cannot be given everyone who has worked on legislative matters during the past year, and the results which they have obtained thus far are concrete evidences of the efforts they have put forth.

On motion this report was adopted.

26 B. JUDICIAL COUNCILORS

(Reports, Jour., May, page 270)

Dr. Allman submitted the following report:

We are pleased to note that the Judicial Councilors have had so little of a controversial nature brought before them. Their individual reports of the work being done in their districts speaks well of the leadership of The Medical Society of New Jersey.

On motion this report was approved.

PRESIDENT CARRINGTON: The committee is discharged with our thanks.

27. REPORT OF REFERENCE COMMITTEE "WEL"

(Report, Sect. 10)

Dr. Clarence W. Way, chairman, gave the following report:

Reference Committee "WEL" has reviewed the report of the Welfare Committee and approves it, and commends the work of the committee as evidenced by the individual attendance and interest and collective accomplishment.

The Welfare Committee, a unique institution in organized medicine, permits The Medical Society of New Jersey to be continuously aware of the wishes of its individual members, and to thus translate that into the philosophy of the State Medical Society.

On motion the House approved the report.

28. REPORT OF SPECIAL REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

DR. HAMMELL P. SHIPPS: The Committee on Resolutions and Memorials is prepared to make a preliminary report:

28 A. DECEASED MEMBERS

Whereas, there has been removed by death since our last meeting on May 17, 1938, a number of members whose names appear in our Official List, be it therefore

Resolved, that The Medical Society of New Jersey in convention assembled, desires to express its deep sorrow and regret in its loss.

This resolution was adopted by a rising vote of the House.

The Journal has published the obituaries of thirty-two members who have died since the annual meeting held on May 17-19, 1938 as follows:

Name	Residence	Date of Death	Age
Hugo Alexander	Hoboken	Sep. 14	51
Frank C. Ard	Plainfield	Dec. 11	62
Jules Baechler	W. New York	Feb. 11	62
Henry Broeser	Hoboken	June 28	69
Charles W. Cropper	Jersey City	Aug. 8	90
Frank W. Curtis	Stewartsville	Feb. 9	74
Elwood Downs	Woodbury	Mar. 8	49
Harold Durant	Paterson	July 15	43
Winborne D. Evans	Camden	June 26	40
Walter W. Gosling	Red Bank	Mar. 4	42
Peter Hoffman	Jersey City	Aug. 1	77
I. W. Knight	Pitman	Apr. 10	57
Marshall F. Lummis	Pitman	Feb. 25	60
James J. McGuire	Trenton	Oct. 11	62
Alexander MacAllister	Camden	Nov. 22	76
Josiah Meigh	Bernardsville	May 26	67
Philip Marvel	Princeton	Sep. 6	82
Ephraim R. Mulford	Burlington	Mar. 10	59
Charles S. Neves	Montclair	Nov. 4	51
Alfred E. Oakes	Elizabeth	Dec. 20	52
George P. Pennington	Atlantic City	June 29	54
Stephen T. Quinn	Elizabeth	Sep. 18	71
Alexander Ross	Haddonfield	Jan. 11	62
Henry O. Reik	Weehawken	June 2	70
Joseph Sesta	Jersey City	July 21	43
Alfred F. W. Sferra	Bound Brook	Jan. 1	45
Herbert L. Strandberg	Carteret	Feb. 24	49
Theodor Teimer	Newark	Oct. 12	67
Henry T. VonDeesten	Jersey City	Sep. 1	59
Harry S. Willard	Ridgewood	Dec. 11	62
Boyd E. Wilkinson	Paterson	Apr. 12	59
James C. Wolfe	Glen Ridge	May 23	41

Editor's note.—In addition to this list, the Journal has recorded thirty-one other physicians of New Jersey as dying since the Annual Meeting of 1938.

Dr. Jackson B. Pellett, of Hamburg, N. J., the oldest honorary member, died May 3, 1939, aged ninety-two years (Jour., July, p. 461).

In addition the deaths of eighteen members have been reported as follows:

Name	Residence
Samuel Adams	Jersey City
John A. Derviaux	Newark
Louis Franklin	Jersey City
Albert G. Gorczyca	Elizabeth
Michael S. Granelli	Hoboken
Philip G. Hood	Newark

Charles L. Ill	Newark
Abraham Mintz	Newark
Charles H. Randall	Newark
Joseph M. Rector	Jersey City
William N. Rogers	Trenton
Robert Schimmelpfennig	Montclair
Robert Sellers	Newark
Frederick W. Steinbock	Avon
W. Hurlburt Tomlin	Wildwood
Reeves B. Van Duzer	East Orange
Alfred F. Van Horn	Plainfield
Lettie A. Ward	Camden

28 B. RESOLUTIONS ON THE PRESS

(Continuation of Section 11)

Dr. Shipps read a revision of Dr. Kler's resolution on the Press, as follows:

Whereas, the newspapers of New Jersey, New York City and Philadelphia have consistently performed a public health function by according a generous amount of space in their news columns to matters relating to health, and

Whereas, the Newark Evening News has coöperated with this Society in its public health program by publishing as a feature of its Saturday issue each week the column "The Story of Modern Medicine", written by members of the Essex County Medical Society, and

Whereas, the Atlantic City Press has also published a special health section during the convention dedicated to The Medical Society of New Jersey, and

Whereas, the correspondents assigned to report the activities of The Medical Society of New Jersey have invariably presented an accurate résumé of the events of the annual convention; therefore be it

Resolved that the House of Delegates of The Medical Society of New Jersey go on record as expressing its appreciation of the fine type of journalism manifested by these and other newspapers in their splendid efforts to keep their readers fully informed concerning health and medical matters.

On motion the revised resolution was adopted.

28 C. RESOLUTION ON THE ESTABLISHMENT OF PRESCRIPTION PHARMACIES IN

DEPARTMENT STORES

(Continued from Section 17)

Dr. Shipps read the resolution concerning the establishment of prescription pharmacies in department stores that is printed in Section 17.

DR. SHIPPS: I move the adoption of this resolution.

DR. DAVID A. KRAKER: I should like to amend that, that the present chain-store drug stores eliminate the department stores. It seems to me that this can't have any real weight, because back of it all a department store determines to set up a pharmaceutical establishment

and it will conform to the law. It seems a waste of our dignity to add this, because I don't think, personally, that this should be voted upon by this organization. It should be voted down.

DR. REEVE L. BALLINGER: It is not a question of law. As I have talked with Dr. Ulmer, who drew up this resolution, it is not a question of law. We realize fully that any department store having a pharmacy department will certainly live within the law; on the other hand, I feel that we should pass this resolution whereby we are not endorsing any such mode of dispensing prescriptions as will be contemplated by what is in back of this resolution.

The department stores in Newark are contemplating that now. Our purpose in putting this in has been merely that we do not endorse as I have said, for the simple reason that on Saturdays during the summer, on Sundays, and on holidays, as well as evenings, these stores are not available; and if a patient comes to your office who has had a prescription filled in a department store, and you wish to find out what you prescribed—you should know, but if you don't and want to refresh your memory—you have no means whereby you can get that information immediately.

I feel that it is probably only a gesture that we go on record as not recommending any such form of pharmacy that we are contemplating doing.

The question was called for.

PRESIDENT CARRINGTON: I do not wish to discuss this motion, for that would hardly be my privilege. I want to call your attention to the fact that the relationship between The Medical Society of New Jersey and the New Jersey Pharmaceutical Association has been perfectly marvelous this year, and I am quite sure that we owe something to our fellow professional confreres.

The motion was put to a vote and was carried.

28 D. RESOLUTION ON THE WAGNER NATIONAL HEALTH BILL

(From Sections 14 B, 32, and 43)

Dr. Shipps read a resolution regarding the Wagner National Health Act, as follows:

The Medical Society of New Jersey, appreciating the need of improvement in methods of distribution of medical care and the cost thereof, and having demonstrated its readiness to cooperate with any and all agencies, governmental or otherwise, to that end, wishes to be emphatically recorded as opposed to the Wagner National Health Act. It is the belief of this Society that this Act is fraught

with danger to the public welfare and has little chance of accomplishing the proposed results. This Society also wishes to make available its facts and personnel to the distinguished Senator in an effort to draft an act that would have a more assured chance of succeeding.

The motion was regularly seconded, put to a vote, and carried.

28 E. PURE FOOD AND DRUGS RECOMMENDATION

(From Section 18)

Dr. Shipps read the resolution on the Pure Food and Drug Act as follows:

We recommend that the responsibility of investigation and study of the Pure Food and Drug Act and all matters concerned with it be allocated to the Committee on Pharmaceutical Problems.

DR. SHIPPS: I move the adoption of the committee's recommendation.

The motion was regularly seconded, put to a vote, and carried.

29. MEMBERS FIFTY YEARS IN PRACTICE

PRESIDENT CARRINGTON: Is Dr. Harry Subin in the room: I want the youngest delegate or alternate. If life begins at forty, Harry has not been born yet. Dr. Harry Subin!

Dr. Subin addressed the Society as follows:

Mr. President and Members of the House of Delegates of the New Jersey State Medical Society:

A few days ago Dr. Carrington became aware of the fact that there were a number of men present who had been associated with this Society for over fifty years. In behalf of the President and the members, a moment is taken out at this time to commend those men who have been connected with this Society for over a half century for the work which they have so creditably performed.

To those men we pay homage and express our deepest regard.

With the closing of this 173rd Annual Meeting those men will have passed the fiftieth milestone in the advance of this Society. But lest they suspect that the passing of this milestone relegates them to a future of inactivity we wish to recall briefly their value to those members who are gradually taking over the reins of management. We have the deepest appreciation for the teachings that have been passed down by those members who celebrate their golden anniversary today. The experience that they have gained by being tanned in the saddle will prove of inestimable value to us who are in the formative ranks.

There are some members who believe that the work in this State Medical Society is restricted to a select few, but the general membership is coming to realize more and more that much wisdom and

sound advice emanates behind the scenes from the men to whom we pay tribute.

If I were designated to offer a pledge to those whom I consider preceptors in the management of the affairs of this Society, I would include the following resolutions:

First, that my colleagues continue to hold the New Jersey State Medical Society in the front rank to which it has been promoted by endless efforts of these men passing the half-century mark.

Second, that the name of the Society be preserved unblemished—and its affairs conducted without intrigue.

Third, that my colleagues be resolved to deal with the public frankly, honestly and scientifically; without regard for private gain, personal ambition, or self-aggrandizement.

Fourth, that whatever faculties we possess be directed toward the continuance and the salvation of the private practice of medicine in its present state of independence so that those who have fostered the ideals and developed the principles of this Society over the past fifty years shall have consolation in their declining years, that their efforts were not expended in vain.

With fondest hope that those to whom we pay tribute and offer greetings today, will return to many more annual meetings, and continue as counselors and guides in the affairs of this Society, my colleagues and I again salute you and wish you God-speed.

LIVING MEMBERS OF THE MEDICAL SOCIETY GRADUATING BEFORE 1891

COMPILED MAY 11, 1939

Atlantic County:

1889—William MartinAtlantic City

Bergen County:

1885—George W. TidwellWallington

1888—William VroomRidgewood

Burlington County:

1883—Joseph StokesMoorestown

1889—Jacob M. DavisBurlington

Camden County:

1881—Howard F. PalmCamden

1884—William C. RaughleyBerlin

1885—John W. MarcyMerchantville

1887—Harry JarrettCamden

Cumberland County:

1880—Edward H. Van DuesenVineland

1890—Charles B. NealMillville

1890—Charles W. WilsonVineland

Essex County:

1875—Edward J. IllNewark

1881—J. Henry ClarkMontclair

1883—Levi W. HalseyMontclair

1884—John H. BradshawOrange

1885—William W. WolfeNewark

1888—Frederick W. BeckerNewark

1888—William H. CookeEast Orange

1888—Wells P. EagletonNewark

1888—Fred HexamerNewark

1888—Harry M. MatthewsOrange

1888—Henry J. WallhauserNewark

1889—Clement MorrisNewark

1889—Caldwell MorrisonNewark

1889—C. Fred WebberNewark

1890—Thompson M. BairdArlington

1890—Edward L. BurnsNewark

1890—E. Zeh HawkesNewark

1890—Jacob S. WolfeBloomfield

1884—Henry RusbyNewark

Gloucester County:

1880—Eugene Z. HillegassMantua

1887—Henry B. DivertyWoodbury

1890—Oran A. WoodPaulsboro

Hudson County:

1883—James H. RosecransHoboken

1885—David R. AtwellHoboken

1885—Levings A. OpdykeJersey City

1889—Lucius F. DonohoeBayonne

1890—George H. SexsmithBayonne

Hunterdon County:

1876—Francis A. ApgarOldwick

1885—Edward W. ClossonLambertville

1889—Theodore B. FulperHampton

Mercer County:

1881—George A. SilverHightstown

1888—Burr W. MacFarlandTrenton

1888—William L. WilburHightstown

1889—John Y. SintonImlaystown

Passaic County:

1883—Bryan C. MagennisPaterson

1886—James W. AtkinsonGlen Rock

1888—John T. GillsonPaterson

1889—William E. ChasePassaic

1889—Daniel E. DrakeNewfoundland

1889—Andrew F. McBridePaterson

1889—Percy H. TerhunePassaic

1890—William FliteroftPaterson

1890—Charles H. ScribnerPaterson

Salem County:

1885—William H. JamesPennsville

Somerset County:

1881—John B. BeekmanBedminster

Union County:

1876—Joseph B. HarrisonWestfield

1882—Frederick A. KinchWestfield

Warren County:

1890—George W. CumminsBelvidere

29 A. DR. JOSEPH B. HARRISON

PRESIDENT CARRINGTON: I am under the impression that the British people are as democratic as we are in America, but they have the delightful custom of symbolizing or personifying their gratitude and their reverence, and that is why they pay tribute to the King at this time. I should like to ask Dr. Harrison to act as the King of Medicine. He has practiced for over fifty years, and will you please rise and take a bow, Dr. Harrison? Dr. Joseph B. Harrison, of Union County.

Dr. Harrison arose amid applause. (See Jour., May, 1937, page 342.)

30. REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

(Report of Committee, Jour., May, page 279)

PRESIDENT CARRINGTON: Will Dr. Alexander make the report of the Reference Committee on Constitution and By-Laws?

DR. ALEXANDER: The Reference Committee III on Constitution and By-Laws approves the two amendments to the Constitution as announced in the Journal of February, 1939, page 118.

On motion the report was approved.
See Sect. 33.

31. REPORT ON GOVERNOR MOORE'S HEALTH AND WELFARE COMMISSION

PRESIDENT CARRINGTON: Dr. Joseph H. Kler, Chairman of the Executive Committee of Governor Moore's Health and Welfare Commission, will give a report on the work of the Commission.

DR. KLER: I have tried hard to make a summary and my best effort is seventy-five pages which I will present to the House.

PRESIDENT CARRINGTON: There is no action for us to take on this report, because the Commission is a creature of the Government.

Editor's note—The report is filed in the Executive Offices of The Medical Society of New Jersey.

Action, Section 41.

32. THE WAGNER BILL

(See Sections 14 B, 28 D, and 43)

Dr. William Tansey, Newark, offered the following resolution:

Whereas State Medicine, Compulsory Health Insurance, and other malicious legislation have come before the people of this great country during these trying times of economic stress; where false ideas are spread to help solve distressing problems, and

Whereas, since the medical profession from times immemorial has contributed unselfishly from its great source of knowledge, income, researches, and labor to benefit the cause of suffering humanity in all walks of life, rich and poor alike, and

Whereas, present laws are being formed to hamper and curtail the individual, inalienable, and constitutional rights of the doctor to carry on this great work for welfare of humanity,

Resolved, that this House of Delegates, representing The Medical Society of New Jersey meeting here, go on record opposing the Wagner National Health Act and other legislation aimed to destroy the fundamental principles of medical ethics and constitutional rights of our American people;

And that we, the House of Delegates, go on record to repel Political Medicine, uphold Constitutional Government, and restore free enterprise among our people.

Upon motion, the resolution was referred to the Committee on Resolutions and Memorials.

Action, Sect. 43.

33. AMENDMENTS TO THE CONSTITUTION

(See Sect. 30)

DR. ALEXANDER: Last year there were two amendments to the Constitution submitted, referred to the Constitution and By-Laws Committee, printed in the Bulletin three months prior to this Annual Meeting, and submitted to each county society for action now, under our Constitution and By-Laws. At this meeting we must decide whether we are going to approve or disapprove these amendments, and the first one I shall read.

Proposed changes in Article V, entitled "House of Delegates" by the insertion of the words "and shall hear appeals from the decisions of the Judicial Council"—and amended Article V will read as follows: "The House of Delegates shall be the legislative body and shall hear appeals from the decisions of the Judicial Council, and shall consist of the Fellows, Officers, and Delegates."

I move its approval.

The motion was regularly seconded.

PRESIDENT CARRINGTON: You have heard the motion and it has been seconded. Are there any remarks?

The motion was put to a vote and was carried.

DR. ALEXANDER: The second proposed change which has up to this time followed the lines set by the Constitution is as follows:

Amend Article VII entitled "Councilors" by changing the word "Delegates" to "Membership".

The amended article will read:

"The House of Delegates shall organize five Councilor Districts within the State. This Society shall elect one councilor from among the membership of each such district and these elected councilors collectively shall constitute the judicial council."

I move its approval.

PRESIDENT CARRINGTON: You have heard the motion.

The motion was regularly seconded, was put to a vote, and was carried.

34. ADDRESS BY FEDERAL COMPENSATION OFFICER

PRESIDENT CARRINGTON: Mr. Turk, the Federal Compensation Officer for W. P. A., would like to talk on indigence and low-wage groups. Do you wish to extend him five minutes' privilege of the floor? So far as I know, that is the only new business to come before us. It is now four-ten o'clock. I will entertain a motion to hear the W. P. A. executive.

SECRETARY STAHL: I move he be allowed the time.

The motion was regularly seconded, was put to a vote, and was carried.

MR. SAMUEL TURK: I am the State Compensation Officer for the Works Progress Administration for the State of New Jersey. As such, our office handles all of the compensation claims for injuries sustained by W. P. A. workers in this State.

We work under the U. S. Compensation Act, which is administered by the U. S. Employees Compensation Commission at Washington. Our office handles only the W. P. A. and some of the old C. W. A. that still requires action. The U. S. Employees Compensation Commission, through a recent bulletin issued to all of the State Compensation Officers, stated, and I quote from the Bulletin:

"To insure the adequacy of medical services obtained on a free basis, and to provide for the equitable distribution of such services among all eligible practitioners, the State Compensation Officers in coöperation with the State Medical Association shall work out the following arrangement for handling medical service:

"1. The State Medical Association should furnish a list of practitioners for each locality in the State, who are desirous of participating in the medical services to injured employees of the Works Progress Administration under the provisions of the U. S. Compensation Employees Commission. The State Compensation Officer should add to this list the names of any other physicians who are qualified and desire to participate in the program.

"2. The State Medical Association should appoint an individual or a committee to survey the

medical services obtained each month as shown on the records for the compensation officer of the State Works Progress Administration, to determine whether its distribution has been equitable. The survey should be made once each month covering the preceding month.

"3. A monthly report should be made by the individual or committee showing the results of the survey. This report should be prepared and sufficient copies to submit two copies to the State Works Progress Commission, and a copy to the State Medical Association. The State Compensation Officer shall transmit a copy of the report, together with any explanation or comment, to reach the Compensation Committee, Division of Finance, Works Progress Administration, Washington, D. C., not later than the last day of the month following the month covered by the survey."

I discussed this bulletin with Dr. Stahl, and it was suggested that it be taken up at Atlantic City, and I suggested if I came down I might iron out some of the problems that might arise.

Is it in order for me to go ahead?

PRESIDENT CARRINGTON: Our procedure is to refer that to a Reference Committee. It will be referred to Reference Committee "MP", Dr. Herschel Murphy, chairman of that committee, which meets at 4:30 in the Green Room.

Action, Section 40 I.

PRESIDENT CARRINGTON: Is there any other new business? If not, this session is adjourned fifteen minutes ahead of time.

The meeting adjourned at four-fifteen o'clock.

Fourth Session of the House of Delegates, Thursday, June 8, 1939

The meeting convened at one-thirty o'clock, President Carrington presiding.

35. REPORT OF REFERENCE COMMITTEE "PH"

Dr. David W. Green, Chairman of the Reference Committee on the reports of the Sub-Committee on Public Health and its thirteen advisory committees, reported as follows:

In conforming with the request of our President for a streamline meeting, Reference Committee "PH" makes the following short report:

We think the members of the various committees deserve the commendation of the rest of the Society for their time and thought given for the benefit of the whole organization.

1. The Reference Committee recommends the acceptance of the Report of the Sub-Committee on Public Health in its entirety. (Jour., May, page 293.)

2. The Reference Committee recommends the acceptance of the Report of the Advisory Committee on Cancer Control. (Jour., May, page 298.)

3. The Reference Committee recommends the acceptance of the Report of the Advisory Committee on Venereal Disease Control, with the provision to continue its study of the problem. (Jour., May, page 309.)

4. The Reference Committee recommends the acceptance of the Report of the Advisory Committee on Adult Health. We call to the special notice of the members their recommendations of the *Radio Hour*, and recommend the Delegates of the New Jersey Society to be instructed to present to the A. M. A. the plan of the *Radio Hour* for the popularization of the annual birthday examination. (Jour., May, page 297.)

5. The Reference Committee accepts the Report of the Advisory Committee on Tuberculosis, and requests the continuation of this work. (Jour., May, page 308.)

6. The Reference Committee accepts the Report of the Advisory Committee on Child Health, and recommends the continuation of this work (Jour., May, page 301.)

7. The Reference Committee accepts the Report of the Advisory Committee on Maternal Welfare, and requests the approval of the Society for the continuation of this important study. (Jour., May, page 303.)

8. The Reference Committee recommends the acceptance of the published Report of the Advisory Committee on Crippled Children for further study by the Society. (Jour., May, page 302.)

9. The Reference Committee recommends the acceptance of the published Report of the Advisory Committee on Pneumonia Control, and suggests that the Legislative Committee request a continuation of this work for years to come. (Jour., May, page 305.)

10. The Reference Committee accepts the Report of the Advisory Committee on Traffic Accidents, and recommends the continuation of the study in cooperation with the Commissioner of Motor Vehicles. (Jour., May, page 307.)

11. The Reference Committee accepts the Report of the Special Committee to Study Eugenic Sterilization, and forthwith recommends the report to the succeeding committee to be immediately appointed by the President of The Medical Society of New Jersey for study, and to contact each component county society. (Jour., May, page 276.)

Respectfully submitted,

DAVID W. GREEN, *Chairman*

FRANK W. ASH

JESSE MCCALL

H. ROY VAN NESS

WILLIAM C. WILENTZ

On motion the report was adopted.

36. REPORT OF REFERENCE COMMITTEE "OFF"

PRESIDENT CARRINGTON: We will now hear the report of Reference Committee "OFF", Dr. Walter J. Farr, Chairman.

The committee considered the reports of:

The President

The Board of Trustees

The Executive Officer

The Secretary

The Addresses of the President.

36 A. TRUSTEES

(Report, Jour., May, page 268)

The Board of Trustees reports that it has had a busy year. The members suggest a different time for their meetings next year, so that they do not have to attend three meetings on the same day.

The Trustees call our attention to the increase of expenses, which they feel is justified; and state that there may be an increase in the assessment.

They have defined the duties of the Executive Officer, the Secretary to the Medical Society, and the Secretary to the Board of Trustees, so as to eliminate duplication of effort.

Their report lists the many activities in which they have engaged, and they need not be repeated here, except to emphasize certain ones:

They discussed the appointment of an Assistant Executive Officer; conferred with delegates to the A. M. A.; discussed the Governor's Health Conference; ordered that the revised Constitution and By-Laws be printed; discussed voluntary health insurance; received the report on the Uniform Medical Practice Act, and many other activities.

On motion the Report of the Trustees was approved.

36 B. LEGISLATIVE AGENT

The Trustees also appointed a Legislative Agent at the request of the Legislative Committee. This committee feels that this was nec-

essary, and recommends it to the House of Delegates. The Board intends this to be a temporary appointment. The Legislative Agent is not a physician.

On motion this report was adopted.

36 C. EXECUTIVE OFFICER

(Report, Jour., May, page 264)

The Executive Officer's report contains nothing of controversial nature. He has reviewed the workings of his office, showing how the aims and plans of the Society are translated into action by the Executive Office. He explains that accounts are audited monthly; that most correspondence of the Society goes through the Executive Offices; that a great deal of his time is spent in Legislative follow-up; and that the cost of the administration of the State Society is not likely to be lowered.

He explains that the weak spot in getting things done is the inertia of the county societies because of their lack of administrative machinery; and suggests two methods of improving the condition:

1. The committees of county societies to be similar to those of the State Society in structure and function.

2. To have the Chairman of a State Society Committee contact the chairman of the corresponding county society committees; and if possible hold at least one yearly meeting with the chairmen of the county society committees.

He then gives a list of activities of the Executive Office for the year.

This committee approves of this report.

On motion this report was adopted.

36 D. SECRETARY

(Jour., May, page 266)

Dr. Farr read a portion of the report dealing with the Secretary's report as follows:

The Secretary reports first that the membership of the Society has increased by 140 this year. Also that the Medical Society's activities are broadened because of the activities of Washington, and the State Society must now protect the individual doctor as well as the public.

The Secretary has attended many meetings during the year.

The Transactions of the Annual Meeting of 1938 were edited; the official list of members was published; and the Constitution and By-Laws was printed in The Journal;—all at a financial saving.

The Secretary has made three recommendations:

1. That the Welfare Committee be composed of Presidents of County Societies, Chairmen of Standing Committees, and Officers and Trustees of the State Society.

This committee does not approve this recommendation because:

1. It feels that it is better to have more men active in the State Society.

2. The President is invited to attend all meetings of the Welfare Committee anyway.

3. The complexion of the Welfare Committee would be violently changed every year.

DR. FARR: We do not approve that recommendation.

Dr. Farr read the second recommendation in this section of the report as follows:

2. That there be more intimate relation between the Medical Society and the Board of Medical Examiners.

DR. FARR: We approve this.

Dr. Farr read the third recommendation in this section of the report as follows:

3. That the Medical Society give consideration to the fact that the income of the Board of Medical Examiners is derived from fees of licentiates and from fines collected.

DR. FARR: This committee feels that this matter should be referred to an appropriate committee for further study.

On motion the entire section of the report was adopted.

36 E. PRESIDENT'S ANNUAL REPORT

(Journal, May, page 257)

Last year Reference Committee "A" made the following report on the address of President-Elect Carrington when he assumed office:

"Reference Committee 'A' has reviewed the program as outlined by the President-Elect, Dr. William J. Carrington. We are greatly impressed by the clarity, extent, and completeness with which this program has been formulated." (Transactions, 1938, page 51, Sect. 53.)

This year we can look back, and see how correct this Reference Committee was in its estimate of Dr. Carrington.

Reference Committee "OFF" has carefully studied the President's Annual Report. We feel that this is a very well-written and comprehensive review of the activities of the Society for the past year; and we recommend it to every member of the Society.

The three objectives of the past year have been well stated and clarify the situation. In the twelve policies enumerated we feel that two deserve special emphasis.

First, the results of the survey of the medical needs should be well known to every physician in the State, and to the general public. The fact that no one in the State was found who needed medical care and could not obtain it, is a very important point.

Secondly, the coöperation with the State in the care of the indigents is a procedure well worth while; and the results of the State-wide survey showing that the physicians of New Jersey contributed over twenty-four million dollars' worth of free care in 1938, should be brought to the attention of every member of this Society. It is pleasing to note that the Medical Society is coöperating with the Governor of the State, and in turn, is receiving coöperation from him.

The President has made six recommendations:

1. Coöperation with Federal and State governments, the A. M. A., social workers, and other allied professional groups. This we endorse.

2. Rejuvenation of the Medical Society by encouraging and training younger men to take active part in county and State Society work. This we endorse.

3. Administration. The President recommends that the administrative years of the county societies and State Society run concurrently.

This committee endorses his recommendations that newly elected officers take office immediately after the Annual Meeting of the State Society.

4. The President recommends that legislation should be offered our State Government only when overwhelmingly approved by the profession.

This we also endorse.

5. We endorse his recommendation that we make progress by *evolution* rather than *revolution*; and continue our Scientific Exhibits, and post-graduate courses.

6. We endorse his recommendation that medical care be better distributed by furnishing voluntary medical care insurance to the middle class.

A resolution concerning this matter has already been introduced to this House, and passed.

He also recommends the pooling of knowledge by the establishment of coöperating diagnostic groups. He emphasizes that these groups must be for diagnosis only, and that the details of organization are purely local affairs.

In conclusion, we wish to highly compliment Dr. William J. Carrington, for the very efficient administration which he has given the Medical Society this year, and for the high degree of success in accomplishing our objectives.

On motion the report was approved.

37. REPORT OF REFERENCE COMMITTEE "PUB"

Dr. James F. Norton, chairman, reported as follows:

The committee has read the reports of the Publication Committee, the Sub-Committee on Public Relations, and the County Society Presidents, and it moves that they be adopted as presented.

On motion the report was adopted.

38. REPORT OF REFERENCE COMMITTEE "PROG"

This committee considered the reports of the Committees on

Program and Arrangements

Sub-Committee on Scientific Program

Sub-Committee on Scientific Exhibits

Advisory Committee to the Woman's Auxiliary.

In the absence of Dr. Joseph Londrigan, chairman, Dr. Norton read the report of the committee as follows:

The committee approved the reports assigned to it as submitted, but would suggest that in the future and in fairness to speakers on the scientific programs and the members of the House of Delegates, the sessions on the first day of the annual meeting begin at noon or early in the afternoon of that day; and that the evening of the first day be used to carry the usual morning session which we now have, and which is not well attended, regardless of whether the program be scientific, or for the conduct of the work of the House of Delegates. This plan would make it possible to carry on the program of the annual meeting within the usual three days of the meeting, and at the same time insure full attendance at all sessions on the first day of the meeting.

A motion was made and seconded that the report be adopted.

Drs. Lewis, Wilkes, Eagleton, Hollinshed, and others discussed the motion, calling attention to the following points:

1. The over-lapping of the meeting hours of the House of Delegates and the Scientific Sections.

2. The poor attendance at the sessions on the first morning.

3. The unsuccessful attempts to solve the problem in the last few years.

Vice-President Morris moved that the hour of the first meeting of the House of Delegates be referred to the Program Committee.

The motion was seconded, put to a vote, and carried.

DR. HOLLINSHED (Chairman, Board of Trustees): Our activities are growing, and it

is a very difficult matter to arrange the meetings so that some part will not feel the squeeze, and I assure the House of Delegates that the Board of Trustees will take this matter into consideration and make every effort possible to correct it.

39. REPORT OF REFERENCE COMMITTEE
"FIN"

PRESIDENT CARRINGTON: We will now have the report of the Reference Committee "FIN", Dr. Edward Sprague, of Newark, Chairman.

39 A. TREASURER'S REPORT
(From Section 6)

The Reference Committee has examined the report of the Treasurer and has found the various items of receipts and expenditures to be in order, and we note that the new system of accounting is of marked benefit to the Society.

The Permanent Fund has a face value of \$15,065.25; but the actual value is less.

The Kipp Memorial Fund received "In memory of Dr. Harry S. Willard" the sum of five dollars, which brings the total of the fund to \$36.65.

Receipts for the fiscal year ending	
May 31, 1939	\$66,089.33
Payments for the fiscal year ending	
May 31, 1939	69,150.15

Leaving an operating deficit of..\$	3,060.82
To meet this deficit the Trustees appropriated from surplus	4,000.00
The cash position ending May 31, 1939, shows a suspense account of	50,944.58
which includes an estimated balance of	21,112.73

The committee again calls your attention to the confusion that may arise because the budgetary year and the fiscal year are from June 1st to May 31st; while the assessment year is from January 1st to December 31st.

On motion the report was adopted.

39 B. FINANCE AND BUDGET
(From Sect. 7)

Several delegates appeared before the Reference Committee asking consideration of the costs of The Medical Society of New Jersey to the individual members. Questions were raised as to the justification of certain activities. Were some lines of endeavor useless or overdone? After briefly reviewing the great amount of work done, the committee is impressed with the sincerity of purpose of the officers and committeemen, and the department

of administration. The good and welfare of the physicians and the distribution of good medical care to the citizens of New Jersey has been the paramount endeavor of the Society. To protect medical practice from uninformed destructive forces and to carry out the altruistic objectives planned by your Society required the expenditure of money.

All details of the budget have been carefully examined, and while the sum total is high, the individual items seem to be needed if the work is to continue on the scale contemplated. The committee respectfully asks that the Trustees review the activities and expenditures with the idea of pruning wherever possible.

As a result of our study, we recommend:

1. That the budget for 1938-39 presented by the Finance and Budget Committee be approved, subject to the review thereof by the Board of Trustees as suggested in this report.

2. The Finance and Budget Committee asks for \$17.00 per member. In our opinion \$16.00 should meet our requirements. The committee recommends that the dues shall be \$16.00 per member for the coming year.

Dr. Sprague moved the adoption of the report.

On motion it was regularly seconded.

PRESIDENT CARRINGTON: The motion is:

First, that the budget prepared by the Committee on Finance be adopted, subject to the approval of the Trustees, and

Second, that the annual dues be set at a figure of \$16.

DR. ALLMAN: I move the adoption of the first part,—that the budget for 1938-1939 presented by the Finance and Budget Committee be approved, subject to the review thereof by the Board of Trustees as suggested in this report.

The motion was regularly seconded.

PRESIDENT CARRINGTON: The motion is that the first part be adopted, that is, that the budget is adopted. Are there any remarks?

Dr. Allman's motion was put to a vote and was carried.

39 C. DUES

PRESIDENT CARRINGTON: The Chair will entertain a motion that the second part of the report be adopted.

DR. SPRAGUE: I so move.

The motion was regularly seconded.

PRESIDENT CARRINGTON: The second part is that the annual dues be set at a figure of \$16.

DR. NORTH: About a month before the annual meeting the committee on Finance and Budget sends to the chairman of every committee a request for a statement of the

amount of money which the committee will require during the coming year. These estimates are added, and the sum is divided by the number of members of the Society. By this process the figure of \$16.75 for dues of each member is obtained for 1939.

On motion of Dr. Eagleton, the meeting went into executive session; and after discussion, it voted unanimously that the dues for the coming year be seventeen dollars per member.

40. REPORT OF REFERENCE COMMITTEE "MP"

This committee considered the reports of the Sub-Committee on Medical Practice, and its nine Advisory Committees. Dr. Herschel Murphy, Chairman, reported for the committee as follows:

40 A. SUB-COMMITTEE ON MEDICAL PRACTICE

(Report, Jour., May, page 282)

The report of the Sub-Committee on Medical Practice is approved. We wish to commend Dr. Allman and his committee on the great amount of good work which they have done.

On motion this report was adopted.

40 B. ADVISORY COMMITTEE ON AUXILIARY MEDICAL SERVICES

(Report, Jour., May, page 282)

The report of the Advisory Committee on Auxiliary Medical Services has been studied by our committee. We agree with it that hospital insurance plans should not include medical services; and that the services of the private physician should be cared for under the Voluntary Health Insurance Plan.

We feel that all clinical laboratories should either be headed by a physician, or else should have a physician who acts in the capacity of a technical adviser; and that after 1942 no clinical laboratories should be recognized by the State Medical Society or the State Board of Health unless it meets this requirement.

We notice in the communication from the New Jersey Radiological Society and the New Jersey Pathological Society that they both express a willingness to adjust their fees to the patient's income when so requested by the attending physician. We feel that their attitude is a proper one. We wish to commend them upon their willingness to coöperate.

We feel that the work of this committee should be continued, and that the members be

commended for the good work they have done. Its report is approved.

On motion this report was adopted.

40 C. ADVISORY COMMITTEES ON CONTRACT PRACTICE

(Report, Jour., May, page 285)

The report of the Advisory Committee on Contract Practice has been studied by our committee. We recommend the adoption of this report and agree with it that the study of this problem should be continued.

On motion this report was adopted.

40 D. ADVISORY COMMITTEE ON INDUSTRIAL INJURIES AND OCCUPATIONAL DISEASES

(Report, Jour., May, page 286)

This committee is a new committee this year, and we feel that in its excellent report it has laid the ground-work for several years to come. We approve the suggestion that the name of the committee be changed to "Industrial Health and Hygiene Advisory Committee".

We feel that the question of preemployment examination is a very important one, and we would like to see the day come when everyone would be examined before starting employment. The report of the committee as a whole is approved.

On motion this report was adopted.

40 E. MEDICAL CARE OF INDIGENT AND LOW-WAGE GROUP

(Report, Jour., May, page 288)

The report of the Advisory Committee on Medical Care of the Indigent and Low-Wage Group has been studied, and we recommend the adoption of this report.

On motion this report was adopted.

40 F. ADVISORY COMMITTEE ON PHARMA- CEUTICAL PROBLEMS

(Report, Jour., May, page 291)

The report of the Advisory Committee on Pharmaceutical Problems has been studied, and we feel that this committee should have the additional duty next year of considering the Pure Food and Drug Act. We agree with this committee in the fact that radio advertising should be under close supervision, and that exaggerated claims of patent medicine advertisers should be banned.

We approve the suggestion of this committee that during the coming year it would be advisable for each county medical society to have a joint meeting with the county pharmaceutical society devoted to the discussion of joint problems.

On motion this report was adopted.

40 G. ADVISORY COMMITTEE ON NURSING
AND NURSING EDUCATION

(Report, Jour., May, page 290)

The report of the Advisory Committee on Nursing and Nursing Education has been studied, and we agree with it that more publicity should be given to the fact that nursing attendants and medical secretaries are now available. We also agree with this committee that it would be unwise to change the present method of training student nurses in our hospitals. While further study is desirable, we disapprove any radical change in the method of nursing education at this time.

On motion this report was adopted.

40 H. ADVISORY COMMITTEE ON WORKMEN'S
COMPENSATION

(Report, Jour., May, page 291)

The report of the Advisory Committee on Workmen's Compensation has been studied. We agree with the principle that the injured or diseased worker should have the right to select his own physician, provided proper safeguards are included protecting him against unqualified and incompetent care, and subject to the protection of the rights of the employer in the fact that he may select a physician if the employee does not or cannot do so.

We suggest an amendment to the present act as it relates to hernia, providing a new bill is not submitted this coming year to the New Jersey Legislature. We agree that the payment for services to the physicians in the case of hernia should be separated from the hospital bill, and that an allowance of \$100 should be made to the physician for operating on a case of hernia.

With the above modifications, we approve the adoption of this report.

On motion this report was adopted.

40 I. WORKS PROGRESS ADMINISTRATION

(From Section 34)

Our Reference Committee has studied the memorandum from the Works Progress Administration and talked with Mr. Samuel Turk, their representative, about it.

We recommend that approval shall be given to continue our present method of medical care of W. P. A. workers for the coming year with the following modifications:

1. That The Medical Society of New Jersey shall communicate with the United States Employees Compensation Commission in Washington, D. C., and recommend that hernias be operated locally in our hospitals by the private practicing surgeon on the case, and not

be sent to Marine Hospitals and surgeons or Contract Hospitals without the consent of a county medical society committee on each individual case.

2. That cases shall not be sent to the Marine Hospital which need further medical treatment merely because the local physician may have treated the patient for thirty days unless a committee from the county medical society approves.

We recommend the adoption of these suggestions.

On motion this report was adopted.

40 J. ADVISORY COMMITTEE ON HOSPITAL
RELATIONSHIPS, AND ITS SUPPLEMEN-
TARY REPORT ON HOSPITAL SURVEY

(Report, Jour., May, page 285; and July, page 414)

We have studied the report of the Advisory Committee on Hospital Relationships, and its Supplementary Report on Hospital Survey. We recommend the adoption of its report with the following suggestions:

1. That municipalities contribute sufficient money to hospitals for the full care of indigent patients.

2. That private patients should not be forced to pay more than their share in order to help meet the deficit in semi-private and ward cases.

3. That out-patient fees should be raised to the point where they will meet the operating expense of the clinic but not to make a profit.

4. That out-patient professional staffs should be brought in closer coöperation with the house staff, administrative staff and governing bodies of the hospital.

5. That the Social Service Department should work under the combined supervision and in close coöperation with the hospital administration and medical staff; and that occasional conferences be held between the county medical society public relations committee and a committee from the Social Service workers to discuss and iron out controversial matters.

6. That physicians be protected from abuse of free service and clinics by proper socio-economic investigation of all patients; and that the State Medical Society go on record that each hospital shall place in its clinic a sign that the clinics are for the indigent only and that it is a misdemeanor according to the New Jersey law to accept free care unless they are indigent.

7. We feel that laboratory fees should be reduced for private patients; and that a flat-rate scheme for all laboratory work while the patient is in the hospital would be desirable.

8. We feel that the staff representative on the Board of Managers should have a vote.

9. We feel that Workmen's Compensation cases should meet the per diem cost for ward cases, or up to \$5 a day.

10. We feel that hospitals should stop collecting fees for the medical and surgical care of compensation cases.

11. We feel that attending physicians should be permitted to charge for the care of compensation cases in all hospitals.

12. We suggest that all accident cases be admitted as private patients until it is proven that they are indigent and not covered by liability of some form of insurance.

13. We suggest that all bills rendered to patients by hospitals have a note on the bottom that the statement is for the hospital bill only and does not cover the doctor's fees.

14. We recommend that every hospital in New Jersey shall have a regular staff and a courtesy staff. The courtesy staff members should have the privilege of doing private work under supervision but not be allowed to do free ward work.

There was a discussion over No. 14 of this report and the Reference Committee proposed that paragraph No. 14 read as follows:

We recommend that every hospital in New Jersey shall have a regular staff and a courtesy staff. The courtesy staff members should have the privilege of doing private work in conformity with staff regulations. An Eligibility Committee shall pass on all applicants' qualifications.

15. We recommend that a copy of this survey, together with our added recommendations, be sent to each hospital and to each member of its Board of Managers or Trustees in New Jersey. With these added recommendations we move the approval of this report.

This suggestion was adopted.

On motion the entire report was adopted.

41. REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS (From Section 31)

Dr. J. Lawrence Evans, Chairman Reference Committee on Miscellaneous Business, gave the following report:

The committee reviewed the conceptions of the Governor's Committee on Health and Welfare. This very coöperative movement to bring together governmental and medical agencies for such a practical survey of health problems in the State of New Jersey is far in advance of that of other sections of this country. It is acting in unison with The Medical Society of New Jersey in endeavoring to ascertain the real situation in respect to health

problems in the State. We must always depend on publicity and alertness of the medical profession for the real care of the ill and the general adjustment necessary between governmental agencies and the medical profession for developing the means necessary to maintain public health.

Although the time available to this committee for the study of the lengthy reports brought out by the general committee and the sub-committees has been very limited, it is our conclusion:

First, that the wise attitude of Governor Moore in creating the committee for the study of public health is fully recognized by our profession.

Secondly, that the general committee and the various sub-committees have done a very valuable service to this Society and to the State, and deserve our utmost thanks for their great contribution to this problem.

Dr. Kler in his Publicity Committee report has already given you a more complete summary than this Reference Committee can compile in the brief period allotted to it. Keeping the effective knowledge of health conditions up to date warrants our recommendation that *a permanent committee be organized to carry on this work of liaison with the necessary governmental committees.*

We suggest that this committee be composed of not less than seven members, which shall include the chairmen of the following committees: Public Health, Medical Practice, and Public Relations.

Respectfully submitted,

J. LAWRENCE EVANS,
D. WARD SCANLON.

A motion was made and seconded that this report be adopted.

PRESIDENT CARRINGTON: What is this new committee to do?

DR. EVANS: It is to maintain a liaison between this Society and any governmental committee that may be working on any public health situation.

DR. READ: The Welfare Committee is organized for the purpose of dealing with all the situations that are to be referred to the proposed committee.

PRESIDENT-ELECT HAWKES: I move an amendment to the motion,—that the recommendation of the committee be referred to the Trustees for action.

The amended report was accepted by the House of Delegates.

42. AD INTERIM MEETINGS OF THE A. M. A. (From Section 14 B)

Dr. Shipps, on behalf of Special Reference Committee II on Resolutions and Memorials, read the following resolution that had been suggested by Dr. Wells P. Eagleton:

Resolved that The Medical Society of New Jersey instruct its delegates to the American Medical Association to call forth and try to enforce:

1. An ad interim meeting of the House of Delegates of the American Medical Association annually, to be devoted solely to the formulation of medical policies; and

2. Measures to give the House of Delegates proper authority to enforce its will and decrees, having control of its own money.

It is the opinion of this committee to approve this resolution in principle. We of the committee feel that there are many points regarding these matters on which various opinions may be expressed. Some differences of opinion exist. We feel, therefore, that this resolution should be carefully considered by the House of Delegates of New Jersey.

The following discussion ensued as to the acceptance of the resolution contained in the report:

DR. SNEDECOR: The experience with the Wagner bill at the annual meeting of the A. M. A. on May 15 in St. Louis showed that sufficient time and study was not being given to the Wagner Bill, and that we should have been in some way well prepared beforehand. The first day of the session it was read off and dumped in the laps of a committee that had never read it or heard of it before meeting at Chicago. No digest of it was prepared, and no analysis of the lengthy law proposed to Congress.

The committee that considered it was at a great handicap for lack of time and for lack of information on what to do with the Wagner Bill, and that is one reason why I think they did as well as could be expected. Their time was limited. Certainly they didn't have time to consider a supplemental bill which I was rather hoping they might propose; so this year at least, it seems advisable to me to consider an ad interim meeting of the House of Delegates. This will merit rather wide support from the other States.

Much controversy will arise over the second part of the resolution on ways and means by which the House of Delegates may regain control over the finances of the A. M. A. which are now exclusively in the hands of the A. M. A. Trustees. To do this will require many talks with leaders from all over the country in order to arouse a sentiment favorable to the change.

Dr. Read suggested that proposing official action at this time would arouse antagonism. It would be better to instruct the New Jersey delegates to caucus with delegates from other states, and so build up a sentiment in favor of our plans. This view was emphasized by Dr. Ulmer.

Dr. Eagleton described the efforts of the

New Jersey Delegates to secure action by the A. M. A.

42 A. ADOPTION OF DR. EAGLETON'S MOTION

DR. SNEDECOR: I make a motion that the principles embodied in Dr. Eagleton's resolution be approved by this House and that they be referred to the Board of Trustees, and to the Delegates to the A. M. A. for decision as to the ways and means of putting the principles into action.

The resolution was unanimously adopted.

43. WAGNER HEALTH BILL

(From Section 32)

Dr. Shipps read the second section of his report, which is as follows:

The resolution submitted by Dr. William A. Tansy regarding the Wagner National Health Bill is approved by the committee.

We feel that the matter has been covered by the acceptance by the House of Delegates of our resolution on the Wagner National Health Bill. (See Section 28 D.)

On motion the report was adopted.

44. AWARDS FOR SCIENTIFIC EXHIBITS

Dr. Asher Yaguda read the awards for original work of Meritorious Excellence in securing, arranging, and managing the Scientific Exhibits. (This list was published in the July Journal, page 453.)

45. PLACE OF ANNUAL MEETING

Dr. Allman moved that the 1940 annual meeting be held in Atlantic City at a time and place to be selected by the Board of Trustees.

This motion was adopted unanimously.

46. PHYSICIAN MEMBER OF THE STATE BOARD OF HEALTH

Dr. Hollinshed, Chairman of the Board of Trustees, introduced the following resolution sponsored by the Board:

There shall be prepared a memorial to the Governor of this State stressing the importance of the appointment to the existing vacancy to the State Board of Health a physician who is fully conversant with the public health problems in relation to the medical profession and public health. That this memorial be accompanied by a list of physicians which in the opinion of The Medical Society of New Jersey are amply qualified to fulfill this appointment prepared by the present President and the President-Elect, Chairman of the Board of Trustees, and that this memorial be presented to the Governor in the name of The Medical Society of New Jersey at an early date.

The resolution was unanimously adopted.

47. WELCOME TO PRESIDENT HAWKES

(Inaugural Address, Section 23)

PRESIDENT CARRINGTON: We now welcome to the platform our new President, Dr. Hawkes.

The assembly arose and applauded.

PRESIDENT HAWKES: I did not expect to say anything now, and have not prepared any-

thing to say, but I don't think we should adjourn without expressing our great appreciation for the splendid work done by our President.

PRESIDENT CARRINGTON: The Chair now declares the One Hundred Seventy-third Annual Meeting of The Medical Society of New Jersey adjourned sine die.

The meeting adjourned at four o'clock.

WILLIAM J. CARRINGTON, *President*

ALFRED STAHL, *Secretary*

Verbatim reports of the proceedings were made by the Master Reporting Company, 51 Madison Avenue, New York.

The original transcription of the reports is on file in the Executive Offices of the Society, 143 East State Street, Trenton, New Jersey.

PART TWO

SCIENTIFIC FEATURES OF THE ANNUAL MEETING

The Scientific Features of the Annual Meeting consisted of four groups of subjects:

- Group 1. Sessions for lectures and discussions.
- Group 2. The Scientific Exhibit
- Group 3. The Exhibit of Medical History of New Jersey.
- Group 4. The Technical Exhibits.

GROUP ONE. SCIENTIFIC SESSIONS

Scientific sessions were held under two general Sub-divisions of Medical Practice:

- A. Administrative Medicine.
- B. The Specialties in the Practice of Medicine.

A. ADMINISTRATIVE

The general subject discussed in the subdivision *Administrative Medicine* was—
The inter-relationships between three participating agencies:

- The doctor as a unit of a medical organization.
- The citizen individually (sick or well).
- Public officials and welfare administrators generally.

Under this subdivision two meetings were held:

- 1. A general scientific session for physicians.
- 2. A joint meeting for physicians and hospital managers.

1. GENERAL SCIENTIFIC SESSION

A General Scientific Session for physicians was held on Tuesday evening, June 6, 1939, at 8:30 o'clock, with the following program:

- 1. Address—"Governmental Planning for Health", by Haven Emerson, M.D., Professor of Public Health Practice, Columbia University Medical College.

Dr. Emerson emphasized the need for clear thinking and accurate definitions in all discussions of public health functions. He defined, simply and accurately, the following terms:

- Socialized Medicine
- State or public medicine
- Health Insurance (sickness insurance)
- Cash Indemnity Insurance

- Periodic Health Examinations
- Group Hospitalization
- Group Clinic Practice
- The Dispensary and the Clinic
- Out-patient Service
- Health Survey, vs. Sickness Survey
- National Health Survey
- National Health Program
- Government Planning for Health

- 2. Address—"Medical Problems of the Day", by Rock Sleyster, M.D., Wauwatosa, Wisconsin, President of the American Medical Association.

Dr. Sleyster contrasted the health survey conducted by the Federal Government with that conducted by the State Medical Societies under the leadership of the American Medical Association.

A survey is like the examination of a patient and is made for the purpose of making a diagnosis. The next step is to institute the correct treatment based on the findings of the survey.

These three addresses are printed in the Journal of July, pages 428-438.

2. JOINT SESSION WITH THE NEW JERSEY HOSPITAL ASSOCIATION

A joint meeting of The Medical Society of New Jersey and the New Jersey Hospital Association was held on the afternoon of Thursday, June 8, with Edward Guion, M.D., President of the Hospital Association, presiding. Two outstanding addresses were given:

1. Dr. W. J. Carrington, President, The Medical Society of New Jersey, gave an address on "The Hospital and the Doctor". Dr. Carrington presented practical subjects in the mutual relations of the doctor and the hospital, such as—

- Hospital Privileges
- Staff Appointments
- Length of Service
- Interdepartmental Relations
- Consulting Staff
- The Doctor and the Superintendent
- Internes
- Sources of Hospital Incomes

2. Dr. G. Harvey Agnew, President, the American Hospital Association, gave an address on "The Doctor and His Workshop", in

3. Address—"The Doctor at the Crossroads", by Nathan B. Van Etten, M.D., The Bronx, New York, President-Elect of the American Medical Association.

Dr. Van Etten pictured the modern conscientious doctor who is harassed and embarrassed under the changes that he is not taking an active interest in the broader fields of medical service.

which he discussed the following subjects in an unusually practical way:

- Staff Privileges
- Closure of privileges to general practitioners
- The clinical and the administrative phases of hospital services
- Coöperation
- Medical representation on Boards of Trustees
- Hospital Care Insurance

These addresses by Drs. Carrington and Agnew are concise and clear, and together constitute a valuable handbook of internal hospital relations. They are therefore printed in the July Journal, pages 410-427, together with a *Survey of Hospital Relationships in New Jersey*, which was submitted as a supplementary report to the House of Delegates on June sixth, covering the relationships as the committee found them after a comprehensive investigation.

The three articles will be reprinted for distribution to the members of the governing boards of the hospitals.

B. THE SPECIALTIES

The general subject discussed in the second sub-division of medical practice was—

The doctor-patient relationships between three agencies:
The doctor individually,
The patient personally,
The public generally.

In the sub-division,—the specialties,—ten meetings were held, as follows:

Combined sections:

1. Section on Eye, Ear, Nose, and Throat, with the Section on Radiology.

2. Section on Obstetrics and Gynecology, with the Section on Pediatrics.

3. Section on Gastro-enterology, with the Section on Surgery.

Single sections:

- 4. Section on Medicine (two sessions).
- 5. Section on Surgery.
- 6. Section on Eye, Ear, Nose, and Throat.
- 7. Section on Gastro-enterology.
- 8. Section on Obstetrics and Gynecology.
- 9. Section on Pediatrics.
- 10. Section on Radiology.

In the section meetings sixty-three subjects were discussed by sixty-three speakers, of whom forty-three were members of The Medical Society of New Jersey, and twenty were guest speakers from other states.

Most of these papers and discussions will be published in the Journal from time to time,

and will be the major source of scientific articles that will appear in the Journal throughout the year.

Full stenotypist's notes of the proceedings of the two meetings of the Sections on Medicine were taken, and will be placed on file in the Executive Offices.

SECTION OFFICERS

The officers of the several sections, to whom the thanks of the members of the Society are due, were as follows:

Section on Medicine:

Dr. John W. Gray, Newark, Chairman
Dr. Thomas M. Kain, Camden, Secretary

New officers elected:

Dr. Thomas M. Kain, Camden, Chairman
Dr. Dean W. Marquis, East Orange, Secretary

Section on Surgery:

Dr. Robert S. Gamon, Camden, Chairman
Dr. Lyndon A. Peer, Newark, Secretary

New officers:

Dr. Victor Seidler, Montclair, Chairman
Dr. C. Abott Beling, Newark, Secretary

Section on Eye, Ear, Nose, and Throat:

Dr. Norman W. Burritt, Summit, Chairman
Dr. A. Russell Sherman, Newark, Secretary

New officers:

Dr. James S. Shipman, Camden, Chairman
Dr. C. Wright MacMillan, Passaic, Secretary

Section on Gastro-enterology:

Dr. Manfred Kraemer, Newark, Chairman
Dr. Hyman I. Goldstein, Camden, Secretary

New officers:

Dr. Hyman I. Goldstein, Camden, Chairman
Dr. Charles D. Smith, Paterson, Secretary

Section on Obstetrics and Gynecology:

Dr. Walter B. Mount, Montclair, Chairman
Dr. J. Carlisle Brown, Atlantic City, Secretary

New officers:

Dr. J. Carlisle Brown, Atlantic City, Chairman
Dr. H. B. Wilson, Hackensack, Secretary

Section on Pediatrics:

Dr. Irving Okin, Passaic, Chairman
Dr. W. Warren Ripley, Montclair, Secretary

New officers:

Dr. W. Warren Ripley, Montclair, Chairman
Dr. Vincent Del Duca, Camden, Secretary

Section on Radiology:

Dr. Milton Friedman, Camden, Chairman
Dr. W. James Marquis, Newark, Secretary

New officers:

Dr. Philip S. Avery, New Brunswick, Chairman
Dr. W. James Marquis, Newark, Secretary

GROUP TWO. SCIENTIFIC EXHIBITS

The most conspicuous and the most available scientific feature of the Annual Meeting was the Department of *Scientific Exhibits*, under the chairmanship of Dr. Asher Yaguda, of Newark. This is the fourth year that Dr. Yaguda has served as chairman of the committee; and from his broad experience he has been able to choose those exhibits which have a practical appeal to the members. On the other hand, exhibitors were anxious to display and explain the results of their work to the crowds of physicians who thronged the exhibit halls at all hours during the day.

Finally, the exhibitors themselves were always on hand, and always found an appreciative group to whom they explained the features of the exhibits.

Fifty-two exhibits were shown, which were listed in the May Journal, page 338.

Ornamental plaques were awarded to the exhibitors as follows:

FOR ORIGINAL WORK OF MERITORIOUS EXCELLENCE

First: Cardiovascular Renal Disease

Drs. F. W. Konzelmann, W. I. Lillie, E. Weiss, L. W. Smith, E. S. Gault, Temple University Medical School, Philadelphia, Pa.

Second: Sphincter of Oddi: Experimental and Clinical Studies

Drs. Ralph Colp, Henry Doubilet, and I. E. Gerber, The Mount Sinai Hospital, New York City

Third: Mechanism and Control of Hemorrhage

Drs. Arthur Steinberg, W. R. Brown, E. A. Schumann, C. T. Beechman, and H. Segal, Kensington Hospital for Women, Philadelphia, Pa.

Honorable Mention: Oxygen in Blood; Clinical Application

Dr. William G. Exton, and Anton R. Rose, Ph.D., Newark, N. J.

FOR EXHIBITS OF MERITORIOUS EXCELLENCE

Open only to New Jersey exhibitors

First: Acute Respiratory Infections

Drs. L. S. Ylvisaker, H. B. Kirkland, and C. E. Kiessling, Newark, N. J.

Second: Diagnosis and Treatment of Pneumonia

Drs. Charles Rathgeber, Joseph Sorett, and S. A. Goldberg, Presbyterian Hospital, Newark, N. J.

Third: What the General Practitioner Should Know About Tuberculosis

Drs. B. S. Pollak and B. P. Potter, Hudson County Tuberculosis Hospital, Jersey City, N. J.

Honorable Mention: Juvenile Hypopituitarism and Hypogonadism

Drs. Rita Finkler, Sidney Keller, B. Rothhouse, R. Bass, E. Ward, Z. Marks, and G. M. Cohn, Beth Israel Hospital, Newark, N. J.

GROUP THREE. HISTORICAL EXHIBIT

The Exhibit of History of The Medical Society of New Jersey blossomed and bore abundant fruit in connection with the exhibit of the Woman's Auxiliary as the result of five years of culture and nurture. The seed for the exhibit was sown by President Lancelot Ely, who took local medical history as the theme of his address at the annual banquet in 1935. It was nurtured by the Woman's Auxiliary, by whose efforts biographies of present-day leaders were collected and bound into four volumes as a demonstration of the richness and value of the records.

The printed minutes of the State Society from the day of its founding are on file in the Executive Offices, and from them the birth and growth of practically every activity of the parent society may be clearly traced. A summary of the attendance of the early members has been charted, and from it the growth of the Society may be clearly traced. These rec-

ords also contain a dozen histories of county societies compiled a half century or more ago from records which have been lost simply because no concerted effort had been made to preserve them.

Enthusiastic physicians in several County Societies have compiled historic records of priceless value,—and the work is hardly started.

The record of this year's historic exhibits is printed in the report of Mrs. Ily R. Beir, Chairman of the Committee on Art, Hobbies, and Medical History, which is printed on page 43 of these transactions. The record of the attendance of physicians at the exhibit especially illustrates the growing interest in the History of The Medical Society of New Jersey and its component county societies.

A summary of the attendance and outstanding features of the exhibit was also printed in the Journal of July, page 453.

GROUP FOUR. THE TECHNICAL EXHIBITS

The Technical Exhibits of the Annual Meeting held on June 6-8, 1939, were more numerous and informative than ever; and they would have been still more extensive if space for them had been available. The exhibitors have learned that it pays them to send their best demonstrators to the New Jersey meeting. A moving

picture of some of the booths in action would be both interesting and informative.

The interest of the members in the Technical Exhibits is shown by the increasing number of exhibitors who apply for booths.

The exhibits were listed in the May Journal, pages 340-342.

PART THREE

THE WOMAN'S AUXILIARY

TO

THE MEDICAL SOCIETY OF NEW JERSEY

The twelfth anniversary meeting of the Woman's Auxiliary was held in Haddon Hall, Atlantic City, N. J., June 6-8, 1939, in connection with the 173rd anniversary meeting of The Medical Society of New Jersey.

REPORT OF THE COMMITTEE ON CREDENTIALS AND REGISTRATION

MRS. R. J. McDONALD, Chairman, Paterson, N. J.

The following table shows the attendance at the Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey, June 7 and 8, 1939:

County	Delegates	Alternates	Members	Guests	Total
Atlantic	6	2	12	2	22
Bergen	3	1	3	2	9
Burlington	4	2	9	0	15
Camden	6	1	8	0	15
Cape May	2	0	2	0	4
Essex	12	1	11	3	27
Gloucester	2	1	2	0	5
Hudson	4	3	5	2	14
Mercer	4	0	3	3	10
Middlesex	6	0	4	1	11
Monmouth	0	0	3	0	3
Morris	0	0	0	2	2
Ocean	3	1	0	0	4
Passaic	7	0	1	2	10
Somerset	1	1	1	0	3
Union	3	2	2	2	9
Warren	1	0	0	1	2
Philadelphia	0	0	0	2	2
					167
					Total
	67	22	61	17	167
Executive Board ...	30				30
County Presidents..	11				11
					208
Total					208

Respectfully submitted,
MRS. R. J. McDONALD.

PRESIDENT'S REPORT

By MRS. DON A. EPLER, President, Newark, N. J.

During the current year, the Woman's Auxiliary to The Medical Society of New Jersey has carried on its activities under the stewardship of our Advisory Committee of Doctors appointed by Dr. William J. Carrington, President of The Medical Society of New Jersey.

Through the efforts of our Advisory Committee Chairman, we have had an appropriation of \$750.00 to assist us in carrying out our educational and convention programs of the State Medical Society.

We particularly stressed the exhibits and history projects—collecting data for Medical Histories of the various county medical societies.

We requested a compilation of the histories of the first ten years of the County Auxiliaries; also of the State Auxiliary.

The Art and Hobby Committee has been busy collecting articles of the handiwork of doctors and their immediate families for the exhibit at the convention June 6th-8th.

An index has been compiled so that the contents of our archives are easily accessible.

An album has been made which contains a brief history of all Past-Presidents of the State Auxiliary, with their photographs. It is being exhibited for the first time at the A. M. A. convention in St. Louis, May 15th-19th, 1939.

A book is being assembled to contain all the activities of our annual meetings.

A book of Journal clippings of the Auxiliary activities from its founding in 1927 to date is being bound.

All these articles will be on display at our Exhibition in June, 1939.

At the request of the Medical Society, photographs of the Past-Presidents have been collected to be hung in the Executive Office in Trenton.

PUBLIC RELATIONS COMMITTEE

The Public Relations Committee has requested every Auxiliary member to answer a card questionnaire giving in detail her standing in lay clubs, to be filed in the Executive Office for the purpose of assisting with medical legislation. This will be an annual procedure.

Health meetings are sponsored, to which lay groups are especially invited.

The Medical Society has asked for the cooperation of the Auxiliary in collecting clippings pertaining to the Medical History and Medical Activities.

HEALTH EDUCATION

Health talks that have been approved by our Medical Society are sent out for publication in club magazines and newspapers, also for distribution among lay groups at Auxiliary meetings.

Reprints from an article on Socialized Medicine by the President of the New Jersey Medical Society have been sent to the counties for the information of their members.

Excerpts from the A. M. A. News Letter, and articles pertaining to the news of the Medical Society have been sent to the counties to be included in their publicity with their Auxiliary news.

An outline of a standard program for an Auxiliary meeting has been sent to each county.

A "question-and-answer pamphlet" has been sent out for the purpose of educating the members, so that they will be in a position to give the Medical Society viewpoint at every opportunity.

Health essay contests are being conducted in schools.

Health committees are organized in lay clubs.

Health Institute meetings have been held for the purpose of furthering preventive medicine, also as a means of promoting authentic information on health to the public.

Auxiliary members are serving as chairmen of health committees in lay clubs, also on advisory boards in lay organizations interested in health, especially projects of The Medical Society of New Jersey.

The Auxiliaries, through their telephone squads, cards, and letters written to the various Senators and Assemblymen, helped with the endorsement of the Medical Practice Bill,—Assembly 210.

WELFARE

The welfare activities of the Auxiliaries are varied. Some contribute to the benevolent funds, blood transfusion funds, nurses' training. Some of the Auxiliaries have used the money to help buy ambulances; others have given their money toward defraying the expenses of their Medical Society.

MEMBERSHIP

We have one Honorary Member, Dr. Clara Renner, who served as a County President, also as Recording Secretary for the State Auxiliary.

The State Auxiliary has a membership of 1,200.

The State Auxiliary paid-up membership is 911.

We have sixteen organized counties.

One county is not active (Monmouth).

One county was reorganized in January, 1939 (Cape May).

Cumberland County in May, 1939, is in a stage of reorganization.

VISITATIONS

As President of the Auxiliary, it has been my pleasure to visit nine Auxiliaries as follows: Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Hudson, Middlesex, and Mercer.

I have presided over all Auxiliary meetings, attended the Advisory Committee meeting in Trenton; and also other meetings as follows:

1. The A. M. A. Convention in San Francisco, California.

2. The Federation Conference in Trenton.

3. The New Jersey Tuberculosis League Conference in Newark.

4. The New Jersey Social Hygiene Conference in Newark.

5. The New Jersey Health and Sanitation meeting in Newark.

6. The Ninth Annual Health Institute in Philadelphia.

7. An evening meeting of Atlantic County Auxiliary at the Ambassador Hotel.

8. The Executive Board of Essex County, and your chairman had the honor of entertaining our National President, Mrs. C. C. Tomlinson, at luncheon.

9. A conference of the Bergen County Auxiliary relative to the Auxiliary disbanding, caused by lack of interest of their Medical Society.

10. A party of the Essex County Auxiliary on May 2nd, 1939.

11. A party of the Hudson County Auxiliary on May 20th, 1939.

12. The Annual Meeting of Essex County on May 22nd, 1939.

13. The Annual Meeting of Bergen County on May 23rd, 1939.

To meet the various problems that are confronting the Medical Society and its Auxiliary today, I would suggest a program be definitely outlined under the supervision of our Advisory Committee of doctors, our President, and the program and public relations chairmen. The object of this program is to educate ourselves before attempting any concrete work for the benefit of the medical society or the public.

Let us through work, love and service help where help is most needed, so that we may be true to the great ideals that lie behind our Auxiliary.

EXECUTIVE BOARD MEETING

The pre-convention meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Solarium of Haddon Hall on Tuesday, June 6, at 2:45 p. m.

The Treasurer, Mrs. T. P. McConaghy, gave the following report:

TREASURER'S REPORT

Report of the Treasurer of the Woman's Auxiliary to The Medical Society of New Jersey

Bank Balance, March 13, 1939	\$ 930.09	Bank Balance, June 7, 1939	\$752.61
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RECEIPTS

Dues—Monmouth Co.—9 arrears....\$ 5.40

Monmouth Co. disbanded and bal-

ance in their treasury..... 6.58

Dues—

Cape May Co.—12 dues 7.20

Middlesex Co.—5 current 3.00

Passaic Co.—23 arrears, 83 current 63.60

85.78

\$1,015.87

DISBURSEMENTS

Mrs. Lippincott, Public Relations

Chairman\$ 4.76

National dues (42 arr., 874 current,
28 adv.) 236.00

President's Pin 22.50

263.26

Bank Balance, June 7, 1939\$ 752.61

Respectfully submitted,

LOUISE M. MCCONAGHY.

RECEIPTS

None

DISBURSEMENTS

Mrs. Salasin, exp. a/c Nominating
Committee\$ 5.42

Mrs. McDonnell, exp. to national
meeting 103.75

109.17

Bank Balance, June 9, 1939\$643.44

Respectfully submitted,

LOUISE M. MCCONAGHY, Treasurer.

Bills were audited and minor business was transacted.

MARGARET BAKER,
Recording Secretary.

MINUTES OF THE TWELFTH ANNUAL MEETING

Mrs. BANKS S. BAKER, Recording Secretary

June 7, 1939

The Twelfth Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Solarium of Haddon Hall on Wednesday, June 7, with the President, Mrs. Don A. Epler, presiding.

Invocation: The Reverend Kenneth Pernichief.

Address of Welcome: Mrs. Andrew M. Smith.

Response: Mrs. J. H. Hornberger.

Mrs. A. Haines Lippincott, Parliamentarian Pro Tem, read the rules and procedure of the convention.

Mrs. G. E. McDonnell submitted the report of the Auditing Committee, which was accepted.

The Recording Secretary read a telegram from Mrs. Frederick A. Kinch extending greetings; and a letter from Mrs. J. P. Simonds, National Chairman of Press and Publicity, advising that she had sent 300 copies of Dr. Irvin Abell's address, "The Position of Medicine in Our Present-Day Culture". These were distributed to the members present.

A telegram of greeting was received from Mrs. Rollo K. Packard, President of the Woman's Auxiliary to the American Medical Association.

Mrs. David W. Thomas, First Vice-President of the National Auxiliary, was introduced.

COMMITTEE REPORTS

Reports of the following committees were given:

Archives, Mrs. C. F. Chianese

Art, Hobby and Medical History, Mrs.

Ily R. Bier

Historian, Mrs. James Hunter

Legislation, Mrs. A. W. Bickner

Press and Publicity, Mrs. W. J. Farr

Health Education, Mrs. H. Roy Van Ness

Public Relations, Mrs. A. Haines Lippincott

Constitution and By-Laws, Mrs. George A. Rogers

Widows' and Orphans' Fund, Mrs. W. D. Minningham

Mrs. Hubbard moved that all the committee

reports and the report of the President be accepted with deep appreciation. Seconded by Mrs. Lippincott and carried.

REPORTS OF COUNTY PRESIDENTS

The Presidents of the following counties presented reports for the year 1938-1939:

Atlantic	Somerset
Bergen	Passaic
Burlington	Ocean
Camden	Middlesex
Cape May	Mercer
Essex	Hudson
Warren	Gloucester
Union	

Editorial note—These reports were on subjects which have been published in the several issues of the Journal throughout the year.

MEMORIAL SERVICE

A Memorial Service was conducted by Mrs. James Hunter in memory of:

Mrs. George H. Wilkinson, Burlington County

Mrs. Mary Ashcraft, Gloucester County

Mrs. Elmer H. Eulner, Middlesex County

Mrs. Howard Nye, Passaic County

Mrs. Vanderhof Disbrow, Ocean County

Mrs. H. V. Hubbard and Mrs. Daniel F. Remer gave very interesting résumés of the convention in St. Louis.

ELECTION OF OFFICERS

The following officers were elected for the year 1939-1940:

Mrs. R. J. McDonald, President-Elect

Mrs. Frank P. Nicholson, First Vice-President

Mrs. O. R. Carlander, Second Vice-President

Mrs. Banks S. Baker, Recording Secretary

Mrs. T. P. McConaghy, Treasurer

Mrs. C. F. Chianese, Director

Mrs. C. B. Russell, Director

Respectfully submitted,
MARGARET BAKER,
Recording Secretary.

MINUTES OF THE POST-CONVENTION MEETING

June 8, 1939

The Post-Convention Meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held

in the Solarium of Haddon Hall on Thursday, June 8, with the President, Mrs. G. E. McDonnell, presiding.

The Treasurer, Mrs. T. P. McConaghy,

submitted a statement showing a balance of \$643.44.

The President announced the new committee chairmen and vice-chairmen.

The *Finance Committee* is to consist of the Treasurer and four members of the Board with Mrs. Chester I. Ulmer as Chairman. It was suggested that committee chairmen submit tentative budgets in detail to the Finance Committee.

Vice-chairmen have been appointed on the following committees:

Organization
Program
Public Relations
Widows and Orphans

Each vice-chairman will have a section. In order to clarify matters the State was divided into the following sections:

<i>Southern</i>	<i>Central</i>	<i>Northern</i>
Cape May	Burlington	Essex
Cumberland	Ocean	Hudson
Salem	Monmouth	Bergen
Atlantic	Somerset	Passaic
Gloucester	Middlesex	Morris
Camden	Mercer	Sussex
	Hunterdon	Warren
	Union	

President McDonnell appointed the following committee program for 1939-1940:

Mrs. Don A. Epler, Chairman
Mrs. H. Roy Van Ness
Mrs. A. W. Bickner
Mrs. Frank S. Forte

MRS. BANKS S. BAKER,
Recording Secretary.

REPORT OF THE ART, HOBBY, MEDICAL HISTORY EXHIBIT

By MRS. ILY R. BIER, Chairman

Because my preliminary report must be completed well ahead of its reading at the Annual Meeting, it is necessary to submit a final report giving accurate account of the Exhibits, the results of our Medical History work, attendance and other matters of interest.

Since exhibitors receive no reward for their trouble and expense other than the appreciation of members, the societies, and myself, it is altogether fitting that a catalogue list of exhibits should be published, and it is included in this report. I have already sent personal notes of thanks to all exhibitors.

The yearly increase in the size of the exhibition, the beauty and attraction of the exhibits, and the number of visitors, both men and women, attest that the exhibition and work of this committee help materially to draw members and their families to the Annual Meeting, and to hold their interest.

The increasing interest of The Medical Society of New Jersey and this committee in the collection, preservation, and exhibition of data and objects bearing on the Medical History of New Jersey has provided a means whereby the State and County Auxiliaries may easily do a valuable job for a cherished objective of the State Medical Society. Again and again I have tried to show County Auxiliary Presidents, by articles in the Journal, by letters, and by distributing copies of instructions to Chairmen of County Auxiliary Medical History Committees during the recent exhibition, how greatly their coöperation will be appreciated by The

Medical Society of New Jersey, and what prestige it will give the Auxiliary.

This year the room used for the exhibition was most satisfactory in every respect. It was large, beautiful, well lighted, and in close proximity to the other features of the meeting. This was a great advantage, and I trust we shall be similarly favored in succeeding years.

I wish to gratefully thank the officers and chairmen of The Medical Society of New Jersey, its Auxiliary, County Auxiliaries, the Editor of the Journal, and the Chairmen of County Medical History Committees for their cordial spirit, and great coöperation and assistance. To merit this I have striven, and shall so continue, to provide greater progress in the Medical History work and a better exhibition each year.

Attendance at the exhibition broke all records. There was a registration of 824, an 80 per cent increase over last year. There were 393 men, a 76 per cent increase, and 431 women, a 90 per cent increase. Because many did not take the time to wait to register, these figures are far below the actual attendance, but they suffice for purposes of comparison.

There were few individual exhibits, but many collections most beautiful and interesting. They filled racks, tables, and twelve large showcases lining a room having 250 feet of wall space. I am very grateful to the many who exhibited this year, and to those who were so enthused that they voluntarily offered exhibits for next year.

There were 57 exhibitors; and 2,090 articles shown. Art and Hobby exhibits to the number of 1,957 were shown by 38 entrants. Medical History exhibits numbering 133 were shown by 19 exhibitors. Of these, 63 exhibits were entered by eleven individual exhibitors, including The Medical Society of New Jersey and State Auxiliary Chairmen, and 70 exhibits by the chairmen of eight County Auxiliary Medical History Committees.

This year our tea was held on Wednesday afternoon, its usual day, and an overflowing audience listened to an address on the Medical History of New Jersey by Dr. Frank Overton. (Jour., July, page 469.)

The list of exhibits is as follows:

ART

Mrs. Samuel Winn, Mrs. A. G. Merindino, Mrs. Victor du Buse, Mrs. Ily R. Beir, Mrs. S. McGeehan, Mrs. William Hershon and Mrs. Herman Wright showed pieces of needlework, embroideries, shawls, samplers, needlepoint or bed spreads.

Photo studies were sent by Dr. Louis Perkel (12), Dr. M. Molitch (2), and Mrs. Frank P. Nicholson (15).

Paintings were sent by Mrs. Levi M. Walker (5), Dr. William Spicker (1), Mrs. W. W. Maver (4), Mrs. D. B. Ackley (1), Mrs. Frank P. Nicholson (1), and Miss Elizabeth Spencer (3).

Dr. A. S. Wescoat sent 1265 pieces of Indian arrowheads, necklaces, pipe bowls, bowls, etc.

Dr. Lancelot Ely sent 19 Indian necklaces; Dr. Dorothy Cross sent 135 Indian patcherds and artifacts with 11 pictures; Mrs. R. B. Walker sent a box of 13 arrowheads.

Mrs. Thomas Conaghy, eight painted dishes.

Mrs. Frank A. Bien, 20 miniature pitchers.

Mrs. James Hunter, 13 pieces hammered copper.

Dr. and Mrs. Charles Kaighn, two pieces silver work.

Mrs. Frank P. Nicholson had eight music books, one music manuscript, 129 old silver spoons, 14 ivories, three charcoal drawings, two India prints, one Cloisone, one ancient jade, two wood crucifixes, four old glass seals.

Dr. Marshall Smith sent three bronze pieces, a plaster statue, a mahogany jewel box.

The Misses de Hellebranth sent 32 pieces of ancient historic and modern Hungarian needlework, embroideries, complete court costumes, and crucifixes.

Mrs. Don Epler brought 17 pieces of family heirlooms, antiques, and embroideries of dogs.

Mrs. B. A. Livengood had 21 pieces of needlework, a tea set, and 10 unusual place cards.

Patsy Uzzell had 23 foreign dolls. Mrs. Andrew Smith sent 48 foreign dolls.

Dr. Edward Uzzell entered 14 sheets of stamps and an album.

Dr. I. R. Beir brought seven meerschaum pipes and holders, and a calabash.

Mrs. James Mason, 14 pieces of spiral glassware, 24 pitchers and one statue.

Mrs. Walter Mount had 13 pieces of pewter, 10 miniatures, one spread, one pitcher and boxes.

Mrs. H. Wellington had two carved Bala wood busts. Mrs. B. A. Livengood had nine wiht combs, and a cocoanut shell necklace.

Mrs. Andrew Smith sent four odd music boxes.

Dr. Chester Ulmer brought a religious German book of 1752.

Mrs. D. B. Ackley had candlesticks and a bowl.

Dr. Joseph Condon brought a Phillipine sword, knife, and brocade.

MEDICAL HISTORY EXHIBITS

Dr. Frank Overton and The Medical Society of New Jersey: Book on Fithean Genealogy, on Seals of Medical Societies; three booklets on Presidents of The Medical Society of New Jersey, 1766-1836, 1836-1885; 1885-1939; Scientific Programs of The Medical Society of New Jersey, 1766-1858; copies of reprint, "An Old Time Country Doctor Shop"; reprints, "Histories of State and County Medical Societies"; group photo Medical Society of New Jersey meeting, Asbury Park, 1893, with indentifications; members attending, photostat first page of original minute book, Somerset County Medical Society; photostat, first page of minutes of meeting of Medical Society of New Jersey, July 23rd, 1766; reprint of photos of officers and chairmen of committees, 1938-39, State Society; group photoprint, Fellows, 1766-1916; official list of Fellows, officers, delegates and member, 1938, ditto 1939; six copies of Journal clipped; list of committees, 1938-39; History of the Medical Profession of Camden County by Godfrey; work sheets on Medical History; Booklet, map, chart, tables, transactions of the Medical Society, 1766-1858; History of Medicine and Medical Men of New Jersey by Wickes; History of Bergen County Medical Society by William L. Vroom; Doctors of Newark by Dr. J. H. Clark; booklet, "Early Days of The Medical Society of New Jersey"; booklet on Organization of County Medical Societies under law of 1816; three articles in the Journal.

Dr. Edward J. Ill brought 15 ancient medical books: one Beaumont, one Morgagni, one Scultetus, one Ruyschi, one Paracelsus, one Harvey, one Oehme, one Eustachell, two Sydenham, one Willis, one Vander Weil, one Hunter, one Celsus, one Descartes.

Mrs. Roy Van Ness sent a poster on Health Education Program.

Mrs. Ray L. Feinstein sent a Scrap Book of the Atlantic County Auxiliary.

Dr. Hilton Reed sent an old bleeding bowl.

Mrs. Chester Chianese, State Auxiliary Historian, sent a book of photos and biographies of Past-Presidents of the State Auxiliary; a booklet, "Meetings of the State Auxiliary"; a booklet of Archives of the State Auxiliary; a booklet of stationery used by the State Auxiliary.

Dr. Charles deT. Shivers, a certificate given his father, Dr. Charles Shivers, for 50 years practice.

Mrs. Clarence Garrabrant, ditto for her husband and a photo of him.

Dr. Chester Ulmer, an old-fashioned ear trumpet; an old combination breast pump and nursing bottle.

Mrs. D. B. Ackley, "History of Medicine and Medical Men of New Jersey", by Stephen Wickes.

Mrs. Don Epler, book, "Photographs Skin Disease", of 1880; and another of 1885.

Entered by Chairmen of Medical History Committees:

Atlantic—By Mrs. Allen Reick: 13 biographies of Past-Presidents of County Medical Society with photos mounted on covers; list of Past-Presidents of County Medical Society; list of medical families; copy of the South Jersey Republican of March 5, 1867; folder of biographies.

Burlington—Mrs. J. H. Hornberger: 150-year-old microscope; old minute book of the County Medical Society; group picture of Dr. Tracey's; group photo of County Society, 1892; group photo of Burlington Hygeia; book on Medical History of Burlington County; folder of biographies, etc.

Camden—Mrs. Ethel A. Roberts: Photo of County Medical Society, 1886; 14 old documents and fee bills; two folders of biographies.

Essex—Mrs. S. B. Jessurun, Mrs. H. N. Comando:

Two books of clippings; book of biographies; photo of Dr. Edward J. Ill; grouped photos, "The Ill Family".

Gloucester—Mrs. B. A. Livengood: Old prescription book; three boxes of instruments; history of County Medical Society; photo and notice, Dr. James Hunter; group photo; program of 100th anniversary of County Medical Society; seven biographies.

Hudson—Mrs. Louis Perkel: Folder of *Entre Nous*.

Passaic—Mrs. Charles Russell: Folder of biographies.

Somerset—Mrs. Lancelot Ely: Framed photo of Dr. G. Beekman, Governor of the Province of New York; Beekman seal, framed; biographies and photos of Dr. Abraham Beekman Mosher and Dr. Lewis Mosher.

Respectfully submitted,

ADELE M. BEIR, *Chairman*,

Art, Hobby and Medical History Committee.

REPORT OF THE ARCHIVES COMMITTEE

By MRS. C. C. CHIANESE, Chairman, Trenton, N. J.

Last January, with the permission of the chair, I took home with me all archives stored at the Medical Offices, in order that I could become acquainted with this branch of work. I discarded duplicates and unnecessary papers; labeled several new folios; and divided the material into five separate groups. To simplify matters when specific knowledge is sought, I made out an index to all contents kept in the archives.

I have been very fortunate in securing stationery of every administration. This folio of sample stationery is useful when seeking information regarding date during which members have served on the Board.

The reports of the annual meetings, taken from the Journal supplements, have been assembled into one booklet. We can add yearly to this collection.

Our President contributed Journal reports dating since 1927. Dr. Overton and his staff have been very kind in assisting us to secure missing numbers. By fall we hope to put these reports in book form, for they are interesting since they reveal the growth of the Auxiliary.

I enjoyed compiling a photograph album of all our State Presidents, with highlights accompanying each photo. The earnest coöperation and response each photo.

All documents received during the year have been filed. We have succeeded in securing a safe and convenient place in the steel files of the Medical Society office for preserving our archives.

Respectfully submitted,

CATHERINE CHIANESE.

REPORT OF STATE HISTORIAN

By MRS. JAMES HUNTER, Westville, N. J.

During the present year an earnest effort has been made by our President, Mrs. Don Epler, to stimulate an interest in the history of the Woman's Auxiliaries of the counties during the past ten years. This project has been sponsored by the National Auxiliary, whose leaders have asked that worthy histories be presented to the annual meeting of 1940.

In order to provide the local Auxiliaries with a guide in their research, the following outline is presented:

1. Give an interesting account of the circumstances surrounding the early organization
 - a. By whom organized
 - b. How organized

- c. Time and place of first meeting
 - d. List of charter members
 - e. List of charter officers
 - f. Nature of early activities
 - g. Interest in Hygeia
 - h. Outstanding line of endeavor
2. A record of each subsequent year
 - a. Officers
 - b. Members holding State offices
 - c. Members holding national offices
3. Information available
 - a. Minutes
 - b. Programs
 - c. Journals
 - d. Private files
4. Clippings and small pictures will add to the interest

IN MEMORIAM

The members of the Woman's Auxiliary to The Medical Society of New Jersey pay tribute to the members who have passed away since the last annual meeting:

Burlington County—

Mrs. George H. Wilkinson, Moorestown

Gloucester County—

Mrs. Mary Ashcraft, Mullica Hill

Middlesex County—

Mrs. Elmer H. Eulner

Ocean County—

Mrs. Vanderhof Disbrow

Passaic County—

Mrs. Howard Nye

ANNUAL REPORT 1938-1939 PRESS AND PUBLICITY COMMITTEE

By MRS. WALTER L. LIEFIELD, Chairman, Rutherford, N. J.

An annual report should outline what you have been trying to do during the past year, how much of your objective has been achieved, and what suggestions you have for the future based on past experience. To eliminate some confusion regarding the duties of the Public Relations, Program, and Press and Publicity Committees.

The Press and Publicity Committee, with representatives from each county, has two specific duties to perform.

1. To furnish the State Journal with a concise monthly report of Auxiliary news. A letter of detailed information, with a sample report for the Journal, was sent to every County President in September.

2. To provide all important newspapers in each county with accurate, detailed publicity on all regular and special activities of the Auxiliary, as well as meetings of lay groups at which physicians are the speakers.

The average of the number of pages of Auxiliary news in the Journal was the same for 1938-39, but newspaper publicity increased. Results in the central and southern sections of the State were better than in the northern counties. The superior organization of club work in the more densely populated suburbs may be responsible in part. However, no matter how varied our club interests are, our first interest and responsibility, outside of our homes, should belong to the profession of our husbands.

REPORTS FROM COUNTY AUXILIARIES

Reports of the Presidents of thirteen County Auxiliaries were given. The subjects of these reports have been described in the Journal

month by month in the Department of Woman's Auxiliary.

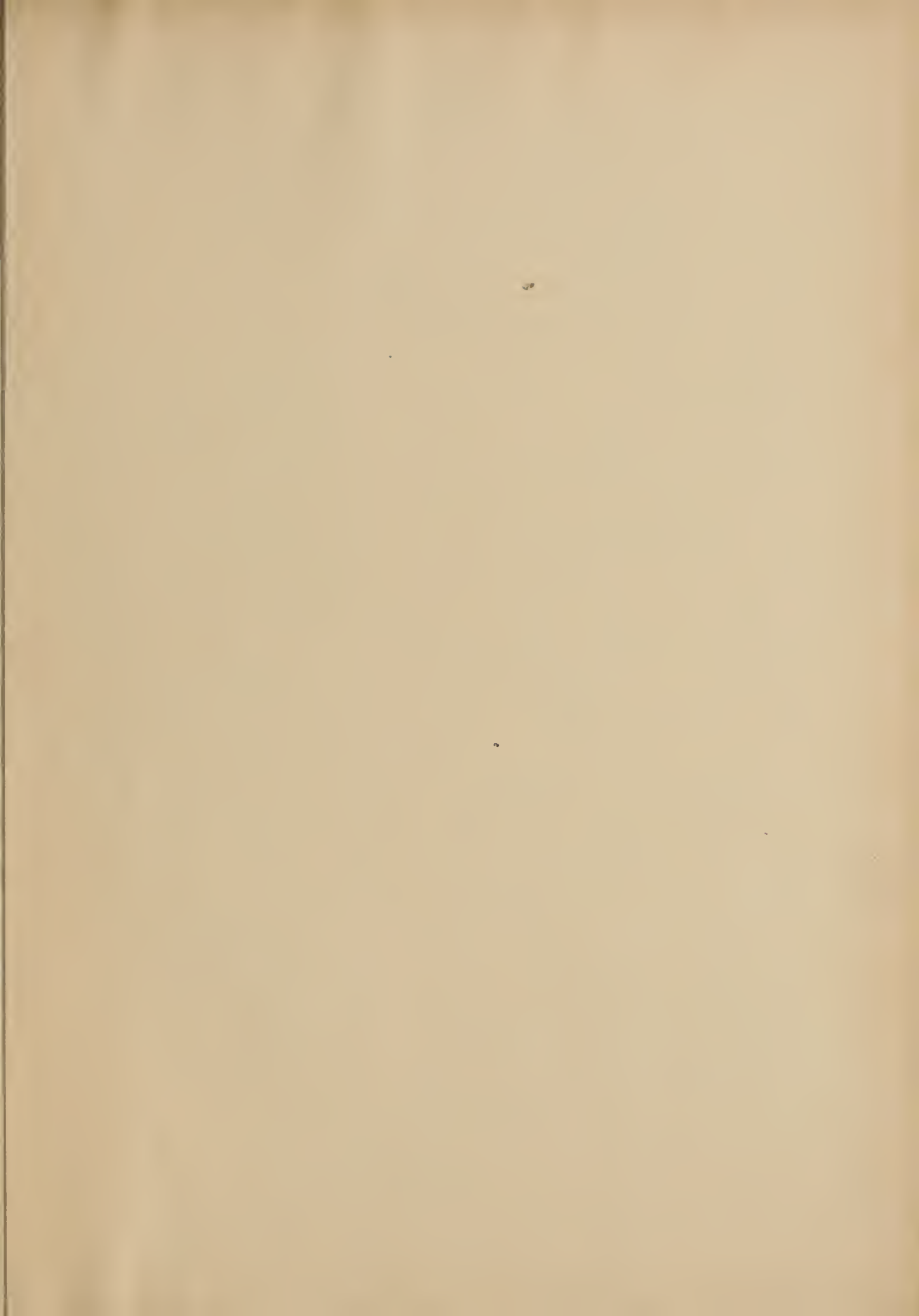
COMMITTEE ON LEGISLATION

By MRS. ALVAH W. BICKNER, Chairman, Rutherford, N. J.

The Woman's Auxiliary has given active support to the legislative bills that have been sponsored by The Medical Society of New Jersey. Influencing public opinion regarding

a high standard of medical practice and public health is a major activity of the Auxiliary.

ELEANOR H. BICKNER.



The New York Academy of Medicine

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